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JULY 1963

GOVERNMENT AND MEDICINE IN BRITAIN

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CURRENT History

JULY, 1963

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In this issue, second in our series on the role of government in providing medical care for its citizens, seven specialists evaluate the comprehensive National Health Service of Great Britain. Tracing the history of the British government's role in medical care, our introductory article points out that "the Health Insurance Act of 1911 . . . set the basis for the National Health Service Act of 1946" and rendered "virtually impossible" the establishment of "truly 'socialized medicine' in Great Britain."

Medical Care before World War II

By SAMUEL J. HURWITZ

Associate Professor of History, Brooklyn College

IN GREAT BRITAIN, as elsewhere, the development of state social services is not a novel phenomenon. However belated, social legislation has been the state's response to social change, the attempt to meet new demands and needs arising out of changes in the fabric of society. The Poor Law of 1601 enacted during the reign of Good Queen Bess served as the basis for almost all subsequent social legislation. Its amendment in 1834 climaxed a *laissez-faire* anti-state intervention attitude, but the change was more apparent than real. The force of events had created needs that could not be met by a hands-off policy.

In an elemental sense, the strength of the state depended upon the health of its citizens. More than that, as Thomas Carlyle had eloquently noted, the illness of the poorest was a threat to the health of the richest. As conditions in the burgeoning towns slid from bad to worse, the squalor and poverty of the slums endangered the health and welfare of the entire community. The abuses, to use Macaulay's phrase, threatened the very

industrialization that created them. These threats were met at first not by actions which centered upon the prevention of individual illness but by legislation designed to clear up and prevent general conditions which were detrimental to the health of the community. These measures were at first mostly administrative, for the purpose of information and to improve efficiency. Only later were laws enacted to prevent the spread of disease. Thus, health services provided by the state before 1900 were piecemeal and fragmentary adaptations to *ad hoc* situations. Though they did not quite grow, as it has been said of the British Empire, in a fit of absent-mindedness, the result was a patchwork, lacking coherent order, without any over-all organization or administration.

Responding to immediate needs, nineteenth century legislation was concerned mainly with protecting the health of the community through improved sanitation. The protection of water supply and the disposal of sewage became matters of parliamentary debate and legislation. As Palmerston said, there

was political warfare between the clean and the dirty parties, leading Disraeli to remark, "*Sanitas, sanitatum, omnia sanitas.*" The first Board of Health was established in 1848 by legislation which also attempted to lay down a common minimum of sanitary services. The Public Health Act of 1875 marked the zenith of the concern with environmental sanitation.

Public and parliament were not prepared, however, to embark on new paths. Though it was recognized that sickness often led to pauperization and was therefore a social liability (in that it increased the need for public and private charity), poverty caused by chronic unemployment even among the physically fit served to blur the social costs of illness as distinguished from general destitution.

It was not until the end of the century that the concept of health as a social asset became more readily recognized. With the development of the citizen army during the Boer War, public and government opinion was stirred by the fact that one-half the eligible population was unfit for service. The Boer War stimulated studies of national fitness; it was found wanting. Health, or the lack of it, became a subject of popular and parliamentary discussion and debate. In 1902, the Inspector-General of Army Recruiting bemoaned "the gradual deterioration of the physique of the working classes from whom the bulk of the army must always be drawn." While the need for better health was so dramatically demonstrated, advances in knowledge seemed to make it increasingly possible to meet these needs. The new era in medicine had begun, and more scientific, preventive medicine could now be practiced.

INCREASING STATE RESPONSIBILITY

The results of the election of 1906 which put the Liberals in power was a significant sign of the times. The period from 1906 to the outbreak of World War I in 1914 was the great era of social legislation in Great Britain, not to be surpassed until the years immediately following 1945. The demands for "social justice" could be delayed, but they

could not be denied. As the problem of poverty was, to quote R. H. Tawney, "recognized not as a problem of individual character and its waywardness, but as a problem of economic and industrial organization," the State was increasingly to become responsible for the health and welfare of its citizens.

The first important measure affecting the health services as differentiated from sanitary legislation was the provision, in 1907, for a school medical service designed to detect preventable disability as early as possible by providing for free medical examinations for school children. This was the first public welfare legislation fully dissociated from the poor law. However small and halting, it was a step forward.

A longer step was provided by the Poor Law Commission Report of 1909. The Report did not provide specific suggestions that were to be incorporated into the National Insurance Act of 1911, but it was the immediate backdrop for the statute. Stressing the crushing effects of illness, invalidity, and unemployment upon the workers, the Commission, though it split over the question of remedies, agreed that the existing measures for relief of the poor were inadequate. Describing the aim of the Insurance Act of 1911, Lloyd George summed up the new philosophy: "We have substituted for tardy relief provision made in anticipation of need." As he said, the new legislation was "infinitely more effective and more kindly in its operation than distress funds or the poor law."

If it was accepted that additional—and costly—legislation was necessary, the question that was yet to be answered was who was to pay for the additional services. Were the costs to be covered by an outright grant from the government, financed out of general taxation, or were they to be paid by the recipients, at least in part? In other words, were the new services to be considered a legitimate responsibility of the state to be enjoyed gratis by the whole or part of the population, or were they to be paid for directly by the individuals affected? The Workmen's Compensation Acts and the Old Age Pension Act of 1908 did not provide for

contributions by the workers, but it was obvious that under the then existing concepts of the limits of taxation, any major new measures could not be financed solely out of general revenue. Those who would receive the direct benefits of the new legislation would have to bear at least part of the costs. The principle of insurance was invoked so that the state would not have to sustain the entire costs of the new services.

NATIONAL INSURANCE, 1911

The National Insurance Act of 1911 was divided into two parts. Part II was concerned with unemployment. Part I, which dealt with health insurance, was modelled in part on the German health insurance legislation. Beginning in July, 1912, compulsory contributions were collected from employers and employees by means of stamps affixed to cards. The plan was based, actuarially, on each member joining the system at the age of 16. Because most of the members joining in July, 1912, were over the age of 16 and many joining in the future would also be older than 16, there was a state contribution of 2d. per week designed to make the plan sound.

Cash benefits, normally of 10s. per week for men and 7s.6d. for women, beginning on the fourth day of illness, were payable for a maximum of 26 weeks beginning in January, 1913. At the end of that period benefits of 5s. per week were to continue as long as the disability lasted. Medical and disability payments ceased at the age of 70. Only individual contributors were covered; dependent members of the insured's family were not included unless they were themselves eligible under the provisions of the act. However, a maternity benefit of a lump sum of 30s. was payable to the wife of the insured and an additional amount if the wife was eligible in her own right.

Because of the high incidence of tuberculosis, there was also a special attempt to provide treatment for this disease. In fact, the Insurance Commissioners were empowered to extend sanatorium benefits to dependents. In addition, 1d. a year from each contribu-

tor was given to medical research, a stipulation which met with a very favorable response in the medical profession. The £57,000 collected in the first year was used immediately to establish the National Institute of Medical Research. From such a little acorn grew the vast field of publicly sponsored medical research in Great Britain.

Medical care, as offered by general practitioners, was to be provided by physicians who joined the health insurance system and who were to be paid a flat fee for each patient. Drugs were to be provided free, as prescribed by the physicians and dispensed by pharmacists who were to receive payments based on agreed prices. Contributors were allowed the free choice of doctors from those who were on the panel. Members were now assured of medical care whenever necessary.

Insured persons were encouraged to enroll in the "Approved Societies." Each society, which had to "provide for its affairs being subject to the absolute control of its members," was given control of the funds collected and was allowed, if a surplus was available, to provide additional benefits, including dental care and care for dependents. Those who did not wish to join a society or were turned down (mostly because they were considered bad risks) were known as "deposit contributors" and the Post Office was utilized for the deposit and distribution of more limited benefits to these members.

There was little difficulty in deciding who was to be covered by the plan and how it was to be financed. Membership was compulsory for all manual workers between the ages of 16 and 70, with certain exceptions, and for non-manual workers whose remuneration did not exceed £160 a year. Provision was also made for voluntary membership by others who were below the income limit. About one-third of the entire population was covered by the scheme. The contributions, which were expected to cover the entire cost of the plan, were apportioned as follows: 4d. per week by the worker, (women paid only 3d. per week) 3d. by the employer and 2d. by the State. Payments and benefits were lower in Ireland. Provision was also made

for workers receiving very low wages, when contribution was to be paid in whole or in part by the employer.

ADMINISTRATION

Given a free hand, it is possible that Lloyd George and his advisers might have worked out a plan which would have been equitable and administratively sound. Operating in a world he never made but in which he wanted ever more political power, Lloyd George, politician *par excellence*, who knew "the twistings and turnings and ruts of the Parliamentary road," surrendered to pressures that he found impossible, or at least difficult, to resist. Faced on one hand by the benevolent or friendly societies and the insurance companies, the livelihood of whose agents, large in numbers and even larger in influence, depended on the existing arrangements for life, sickness and burial insurance, Lloyd George felt compelled to include these organizations in the administration of health insurance. Faced by the protest of organized medicine over being excluded under the original plan from the administration of medical benefits, Lloyd George gave them a voice by providing for local committees, upon which they were to be represented, to administer the medical benefits.

On the national level, separate machinery was established under four (one each for England, Wales, Scotland, and Ireland) linked commissions. This newly-formed administrative body, the Insurance Commission, which was given very wide powers, was made necessary by the fact that the Local Government Board under John Burns was still influenced by the dominant tradition of the old Poor Law Board, characterized as a "tradition of cramping the local authorities and preventing things from being done."

Thus, the Local Government Board, which would normally have been the administrative body for this type of legislation, was bypassed, just as it had been by-passed in the administration of other social legislation enacted in this period.

A new precedent was set for social insur-

ance legislation in the British welfare state when the Act of 1911 introduced direct payments by the insured. Indeed, this was a complete reversal of the previous trend. In the past, all the measures of social reform from the Education Act of 1870 down to the Old Age Pension Act of 1908 provided "something for nothing." Lloyd George might now raise the cry that the workers would receive "9d. for 4d." but the 4d. was an unwelcome innovation and burden.

The apportionment of costs was accepted by most but attacked by many. Labor opposed the enforced contributions by workers at a time when the average wage for men was 30s. for a 54-hour week and 13s.6d. for women. No wonder George Bernard Shaw, then an active Fabian, attacked the bill as "monstrous" and characterized it as "a bill to enforce savings on people who already can't afford to feed themselves properly." Employers of domestics also organized protests, dramatized in a campaign against "stamp-licking."

Nevertheless, as a whole, the National Insurance Act of 1911 was one of the least controversial of the major measures passed by the Liberal government. As Austen Chamberlain confessed in the privacy of his diary, "Confound Lloyd George. He has strengthened the government again. His sickness insurance is a good one." Lloyd George himself was less modest. The Act, he proclaimed, was "doing the work of the man of Nazareth." Winston Churchill, as Home Secretary, hailed the National Insurance Bill as "the most decisive step taken upon the path of social organization."

The doctors, who originally threatened to strike over the question of compensation, were less than enthusiastic. In his address of 1912 before the British Medical Association, the president of the organization prophesied that the act would produce "a race of gently reared hot-house plants." However, in retrospect, the organized medical profession hailed the 1911 act as "in its conception one of the greatest attempts at social legislation which the present generation has known . . . destined to have a profound influence on

social welfare and the health of the community." Thirty years of experience with the bill led a committee appointed by the British Medical Association and other professional medical groups to hail the National Insurance Act as "a greater success than was anticipated either by its supporters or by its opponents."

The medical profession had reason for the change of heart. The effect of the new legislation was very significant. It is estimated that the income of the average physician almost doubled as a result. Concomitantly, medicine became a profession of status for the first time. Before 1911, it might have been possible to have made doctors full time salaried public employees; the 1911 Act, by providing for an alternative method of medical care, set the pattern for the future.

Lord Cranborne, later to be Lord Salisbury, said back in 1867 when he opposed Disraeli on parliamentary reform:

It is the duty of every Englishman and of every English Party to accept a political defeat cordially, and to lend their best endeavours to secure the success, or to neutralize the evils, of the principle to which they had been forced to succumb.

The Health Insurance Act of 1911 was a milestone, but not the goal. The Act had grave defects both in its provisions for administration and coverage. It was soon recognized that medical benefits, at least, would have to be extended to dependents, that additional services would have to be made available under the medical benefits, and that the administration would have to be radically changed. The vested interests who were involved in the outcome of the 1911 Act, the trade unions and benevolent societies, the insurance agents and collectors, and the doctors, had not prevented passage of the bill but had managed by insuring a considerable windfall for themselves to make its administration expensive and complicated. It was estimated by Treasury officials in 1911 that by administering the act exclusively through the Post Office, the benefits could have been doubled without the need for additional contributions. The complicated setup caused

George Bernard Shaw, the disciple of Fabian efficiency, to exclaim that the official machinery for the administration of health insurance would "make even the millenium a nuisance."

From almost the inception of the new program, there appeared a veritable flood of surveys, reports and plans for change. The organized medical profession was in the forefront of the campaign for change and called for "a planned national health policy." Though the British Medical Association was careful to announce that British medical services were better than those of any other country, it admitted that they were neither good enough nor the best attainable. Its report in 1926, which is in many ways typical of other reports, criticized the lack of provision for laboratory and nursing services, and for consultative and specialist services. The report called also for the inclusion of provision for hospital care and observation. Without these additional services, the doctors reported that they were hampered in making accurate diagnoses.

From 1911 on, there had been numerous amendments to the original act, but not until 1946, with the passing of the National Health Service Act, were any basic changes made. The principal changes before 1946 were increased contributions and benefits, the limitation of voluntary membership to those who had been compulsory members, the reduction of the age limit for compulsory insurance from 70 to 65 years of age, and the extension of benefits to those who had been unable to keep up payments because of lengthy unemployment. In 1936, the minimum age of

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The National Health Service in Britain was designed "... to provide steadier and more abundant medical finances, to redistribute manpower and facilities, to improve clinical conditions and to achieve the most efficient use of facilities by proper coordination and a proper distribution of workloads," in addition to providing "free medical care."

The Genesis of the National Health Service

By HARRY ECKSTEIN

Professor of Politics, Princeton University

COMMON BELIEFS to the contrary notwithstanding, the British National Health Service Act of 1946 was *not* imposed by the Labour government of 1945 on a grimly opposed medical profession nor railroaded through a sharply divided House of Commons by Labour's overwhelming majority. In all but minor detail, the Act was a bipartisan measure and supported (again in principle, if not in every detail) by the great majority of British doctors. The wide support enjoyed by the Service today already existed at its genesis.

Americans may indeed be astonished by the attitude of the British medical profession toward the construction of the N.H.S. The British medical associations, far from fighting desperately against the Service, did little more than play for time and haggle over details, partly to help shape the general administrative structure of the Service, partly to get particular advantages for their members. The fact that at one time a strike

was threatened against the Service does not alter this point; the strike threat was just a gambit in the bargaining process, designed to shape the Service, not to sabotage it. The doctors in fact were not merely acquiescent; they had as much to do with the construction of the N.H.S. as anyone else, indeed more.

Prior to 1946 there had been in Britain long agitation for reform of the medical system. This culminated in (rather than started with) the famous Beveridge Report on social security—a report recommending a comprehensive public medical service and accepted by Churchill's wartime government of all parties.¹ We find doctors in the forefront of this agitation at almost every turn—and not only unusual doctors (like the members of the rather negligible Socialist Medical Association) but even the large national medical associations, the British Medical Association (B.M.A.), the Royal Colleges and the British Hospitals Association. The last of these, representing "voluntary" (i.e. private) hospitals, produced, in 1937, a very ambitious plan for the total reorganization and central planning of British hospitals, public *and* private.²

Seven years earlier, the B.M.A. (of all people) had produced an even more am-

¹ Sir William Beveridge, *Report on Social Insurance and Allied Services*, London: H.M.S.O., 1942. The report did not go into the shape of the future service in detail. It merely postulated, as one of three basic assumptions, that in future a national service for the prevention and cure of disease and disability would be established (para. 426).

² B.H.A., *Report of the Voluntary Hospitals Commission*, 1937.

bitious plan recommending a fully comprehensive compulsory health insurance system (a sort of super-"medicare") and the national coordination of medical services under "a planned national health policy."³ And these were only beginnings. By 1942, the year of the Beveridge Report, the British doctors were in the throes of a veritable reformist fever. That was the year of the report of the Medical Planning Commission, a most remarkable body and a most remarkable report.⁴ The Commission had been organized by the British medical bodies themselves. It consisted of 73 members and was, according to J. S. Ross, "the most representative body ever established by the medical profession," a plausible point since the B.M.A. endorsed all of its recommendations. These recommendations were in essence that all should have unimpeded access to all medical services and that to this end there must be comprehensive medical planning by public authority, with general practice concentrated in large "health centres" and hospitals organized and coordinated on a large regional basis.

The Medical Planning Commission, in short, recommended a full-fledged national health service *before* the publication of the Beveridge Report. The doctors gave the lead; the politicians followed. In view of this behavior by the medical profession, it is not surprising that the events leading to the Health Service Act did not involve much political controversy. Although Churchill had promised not to prepare "controversial" legislation during the war, steps were initiated shortly after the government's acceptance of Beveridge's Report to implement his recommendation of socialized medicine. For about a year, government officials consulted representatives of the medical profession and of local government authorities (whose services were to come under the scheme); these con-

sultations seem to have gone very smoothly. Then, in 1944, a White Paper appeared which outlined, in all major respects, the Service Labour was later to enact.⁵ Few announcements of policy have had a more enthusiastic reception in Parliament,⁶ and the government then immediately embarked on the process of drafting legislation presumably because the issue did not appear at that point in any way controversial.

OPPOSITION TO THE N.H.S.

The story of the creation of the N.H.S. is not, however, one of unqualified sweetness and light. Even before the appearance of the White Paper, the profession's feelings had begun to cool somewhat; the honeymoon phase of medical reform, like most honeymoons, did not last long. The reasons are simple. Before Beveridge, planning for medical reform had consisted entirely of paper exercises, the object of which was to design an abstractly efficient medical service. Now, with actual legislation contemplated, other considerations came to the forefront. The profession now became concerned, naturally enough, with getting for itself maximum personal advantages. Just as naturally, it wanted a Service which would require only the most minimal changes in the personal and clinical habits of the doctors.

Immediate practical questions of administrative organization thus loomed much larger now than more academic questions about the proper organization and distribution of medical services, and on these practical administrative questions there was considerably less agreement. More important still, the very fact that medical reform was no longer a subject merely for cozy professional shop-talk, but one in which laymen politicians and bureaucrats would inevitably have to play a leading role, seemed to fill the British medical leaders with a nameless dread. Wild rumors, without the slightest basis in fact, began to fly: general practitioners were to be rooted out of their established practices and herded into health centers, all doctors were to work on salaries (and rather low ones at that), the profession was to be closely con-

³ B.M.A., *A General Medical Service for the Nation*, London, 1930 and 1938.

⁴ For the report, see *British Medical Journal*, 1942, I, pp. 743-753.

⁵ Min. of Health, *A National Health Service*, H.M.S.O., Cmd. 6502/1944.

⁶ 398 H.C. Deb.. pp. 427-533.

trolled by central bureaucrats and local politicians, and so on.⁷

All this clearly indicated panic at what the medical profession itself had helped to bring about, as did the B.M.A.'s sudden request that legislative plans be temporarily suspended pending an inquiry by a Royal Commission—a body perhaps more useful for delaying action than for bringing it about.

The White Paper, to be sure, allayed the more baseless fears of the profession. Most of its non-administrative provisions were in fact approved by large majorities in a plebiscite of the profession conducted by the B.M.A. itself.⁸ But the medical leadership continued to play for time (by insisting, for example, that nothing should be discussed with the government until specific administrative questions—the issues most likely to stall negotiations—had been agreed upon by all sides). Negotiations between the Ministry of Health and a special medical negotiating committee did follow, but we do not know what they were about; in any case, there was a certain unreality about them since the life of the wartime coalition was about to end.

About a year after the White Paper's appearance the general election of 1945 took place, just when the B.M.A. was holding its annual representative meeting ("convention" in American language). An ironic cheer was raised at the meeting when Sir William Beveridge's defeat in the election was announced, ironic because the Labour party, which was committed to speedy medical legislation, swept into power with a massive majority.

ACCELERATION

Still, even during the gloomy, anxious months which followed the Beveridge Report, the parties remained substantially at one and the medical profession substantially remained committed to some sort of socialized medical service. The election of 1945 did not decide anything in regard to socialized medicine, but merely accelerated the legislative process.

It did so not least because it brought to the Ministry of Health a mercurial personality, Aneurin Bevan. The profession still wanted to spin things out, but Bevan was no temporizer. He felt that the views of the doctors were already well-known and that these views should be "considered" in drafting legislation, but that doctors should be given no veto over legislation; while he was willing to "negotiate" with the profession over terms of service he would only "consult" with it about the general shape of the N.H.S. So, while the profession's negotiating committee cooled its heels, Ministry officials went about the business of drafting legislation, not totally without further counsel (some 30 meetings were held with interested parties)⁹ but with no intention of letting consultations cause long delays. The law was passed in November, 1946, and the medical profession was caught in a highly ambiguous position—committed to the Service in principle yet chagrined by the Minister's unwillingness to accord it a larger role in the final drafting process.

This does not imply that the National Health Service turned out to be a layman's service after all, or that it was in the end imposed upon a deeply reluctant medical profession. Not only did the profession remain committed throughout to the principle of large-scale medical reform, but Labour's scheme was very faithful to the coalition's White Paper, which had been closely worked out with all interested parties and much inspired by the M.P.C.'s report of 1942. Furthermore, the National Health Service prescribed only a thin administrative framework which was to be filled out by voluminous delegated legislation; all such legislation Bevan was entirely willing to negotiate with the medical profession and did in fact negotiate with it.

The process of transforming the generalizations of the N.H.S. Act into a functioning service took almost two years and inevitably involved some fierce in-fighting. The most widely publicized battles between ministry and profession fall into this period: two further plebiscites were held in which the pro-

⁷ See, e.g., *Brit. Med. J.*, 1943, I, Suppl., p. 61ff.

⁸ *Ibid.*, 1944, II, Suppl., p. 25ff.

⁹ See 422 *H.C. Deb.*, p. 60.

fession voted strongly against the Service and plans were hatched to mobilize the doctors for a strike. But these events should not be given undue weight. After all, they occurred *after* wide agreement on general principles had been reached; thus they do not show opposition to socialized medicine as such but doubts about specific administrative proposals and, to some extent, sheer irritation with Bevan.

MEDICAL FEARS

What is more, doubts about the details of the scheme were heavily concentrated on a very few points: the possibilities that general practitioners would be paid by salary (the chief bogey of the B.M.A.), that they might be denied the right to practice privately alongside their N.H.S. practices, and that they might be "directed" by the Ministry (that is, told where to practice). When the Minister agreed to introduce amending legislation to make salaries for general practitioners illegal and gave definite assurances on the other points, opposition declined steeply and all talk of a strike ceased. Even before that, only a small minority of doctors had contributed to the "fighting fund" established to support the profession in case of a strike,¹⁰ and at least one large and important segment of the profession, the specialists, had been throughout almost entirely non-belligerent. Furthermore, at no time had the profession tried to mobilize public opinion against the Service or to conduct a general public relations campaign in the A.M.A. manner. In the end the Service went smoothly and peacefully into operation on its Appointed Day.

WHY REFORM?

Before tracing the shape of the Service which emerged from these processes, it might be worth asking why there was so little public disagreement on socialized medicine in Britain, so much medical pioneering of re-

form, and (considering what was at stake and bearing in mind the vastly different American experience) so little really virulent conflict when the legislative chips were down. Many reasons are involved, and they are all instructive.

One reason, no doubt, is that British pressure groups in general are far less effective in killing off government policies than American blocs; hence they usually try to shape undesirable legislation to their own ends rather than to prevent it. The reason for this in turn lies in the general structures of the British and the American governments. The American system is wonderfully suited to the destructive pressure group because it gives power (in one way or another) to so many groups and individuals to stop legislative projects—the President, either house of Congress, committees in either house, sub-committees, and chairmen of committees and sub-committees. A defensive pressure group that succeeds at any one of these points can achieve its ends.

In Britain, however, governmental powers are highly concentrated in the Cabinet, which almost always enjoys highly disciplined support in Parliament. Once the Cabinet decides on a policy, as it did in this case as early as 1942, pressure groups can do little but try to participate in its detailed shaping, and that is what they in fact usually do.

But why so much commitment to medical reform even before government policy was formulated? The answer is in part that the British medical system by the time of World War II was in pretty desperate condition. There were considerable shortages in facilities and manpower. The existing services were very unevenly distributed, less perhaps among social classes than geographically and functionally.¹¹ Shortages and maldistribution were aggravated by the uneconomic use and irrational organization of existing facilities. Most medical sectors, but especially the hospitals, were acutely starved for funds, due to the constantly rising costs of services and the insidious decline of old sources of finances (such as philanthropy). Not least, the clinical conditions under which medicine

¹⁰ See *Brit. Med. J.*, 1949, I, p. 186.

¹¹ By "functional" maldistribution I mean a shortage of certain kinds of facilities (e.g., mental hospitals) and an over-abundance of others.

was practiced were widely obsolete—small, dingy, ill-equipped hospitals and general practitioners' surgeries generations out of date were all too common.¹²

Still, as we all know, the mere existence of inadequate medical services does not inevitably produce support for their reform—least of all medical support. It is necessary also that people should be aware of the inadequacies, that the medical system should be known by its over-all shape rather than by merely its more conspicuously successful practitioners and institutions. What then made the British so aware of the shortcomings of their system?

WAR AND MEDICAL REFORM

The answer undoubtedly is the war. Expecting even more virulent air attacks and more massive civilian casualties than actually occurred, the British began, as early as 1938, to inventory and evaluate their medical capabilities, a process which starkly and mercilessly revealed faults hardly even suspected before. For example, a most detailed national survey was made of all hospital facilities (beds, specialists, operating and pathological equipment, and so forth); the results were compared with certain minimal hospital requirements, and this simple exercise revealed problems of scarcely imagined dimensions.

Even this is not the whole story. The war, as we have seen, only intensified an already strong movement for medical reform. Besides, to recognize the inadequacy of a medical system does not automatically reconcile one to socialized medicine; it is always possible to believe that the cure is inappropriate to the disease. What then made the British doctors so astonishingly willing to have socialized medicine?

One reason certainly is that the long operation of a public health insurance system (since 1912) had banished the more acute and unreasonable fears of governmental involvement in medicine. Another reason is

rather more subtle. To put it in essence: the British medical profession has never been so deeply imbued with commercial mores as, say, the American. In all societies, commercial and professional roles differ in important ways: in commercial transactions the object is to work out advantageous exchanges, in professional transactions it is to provide technical services to people who often desperately require them. The exchange of values is essential in the first case but only incidental in the second. Each role can, however, become imbued to some extent with the norms of the other; businessmen can think of themselves as altruistic providers of necessary services, professionals become strongly oriented to extracting money from their clients.

The point is of course that the British medical profession has been much less affected by the commercial ethos than the American profession and thus was less concerned with preserving the essentially commercial private fee basis of medical practice. No doubt this is largely due to a class structure still deeply imbued with aristocratic values of public service and aristocratic prejudices against "trade"—a point supported by the fact that specialists, the more prestigious segment of the medical profession, were significantly more in favor of the N.H.S. than general practitioners.

In the very end, however, the tide of medical opinion was swung behind the service by still another factor: the willingness of the government to yield to specific medical preferences and give the profession an extraordinarily powerful role in the operation of the Service. Most of these concessions were made in the negotiations following passage of the N.H.S. Act, but some were written into the Act itself. This point will be clearer after we look at the structure of the Service.

N.H.S. STRUCTURE

The Service which came into being in 1948 had a very complicated structure, necessarily so since it was not designed for simple purposes. It was not merely to provide free medical care. Equally important (and a

¹² I have documented all this at length in my book, *The English Health Service*, Cambridge, Mass., 1958, ch. III.

clear requisite for the achievement of the "medicare" objective) was the desire to provide steadier and more abundant medical finances, to redistribute manpower and facilities, to improve clinical conditions and to achieve the most efficient use of facilities by proper coordination and a proper distribution of workloads.

Also the administration of the Service was to realize certain democratic values of decentralization and voluntary participation and to provide a sufficient voice for the medical profession itself. No short sketch can do justice to a structure designed to achieve such complicated ends, and anyone genuinely interested in the subject should look at one of the many books written about it. Here we can only provide the barest sketch.

The administration of the N.H.S. is carried out by three sets of bodies under the general direction of the Ministry of Health, aided by a large professional advisory committee. One set is concerned with general practitioner services (medical, dental and ophthalmic), another with hospitals, and a third with various auxiliary services, such as health visiting, ambulances, vaccination and immunization.

(a) *General practitioner services* are provided free to all (except for nominal charges on certain dental and ophthalmic services and prescriptions). To get general medical services one simply registers with a doctor of one's choice; the doctor is then obliged to provide all normal general practitioner services, in return for which he is paid an annual fee—a "capitation payment"—for every patient on his list (a method of pay insisted on by the doctors themselves). Doctors may refuse patients they do not want to serve; patients may transfer freely from one list to another; every general practitioner has the right to carry on as much private practice as he can get; there is a large maximum limit on the number of patients a doctor can take on; and special inducements are offered to doctors willing to practice in partnerships or groups or in badly underdoctored areas.

Basically doctors can practice wherever

they like; however, a special body, composed primarily of doctors, keeps a constant check on the adequacy of doctoring in various parts of Britain and may close off heavily overdoctored areas to new men, a power so far used rather circumspectly. General administration of the general practitioners' services is in the hands of local Executive Councils, on which professional men appointed by local professional committees predominate. Clearly the basic idea behind all this is to achieve a maximum of self-administration, a gradual and voluntary reconstitution of general practice on a group basis and a gradual redistribution of personnel without outright direction or immediate hardship to anyone.

(b) *Hospitals* were taken over by the Minister on the Appointed Day and fundamentally reorganized. Hospital planning is directed by Regional Hospital Boards, each responsible for a large area centered on a teaching hospital (i.e. medical school), though these teaching hospitals are not subject to the Boards but have their own administrative committees. The members of the Boards serve on a voluntary basis; they are not bureaucrats but all manner and conditions of men and women, with medical practitioners the dominant element. Under the Boards, hospitals are grouped in "management committees" which carry on day-to-day administration. These committees are also voluntary bodies in which there is a heavy sprinkling of medical practitioners. Both Boards and Management Committees have the services of full-time, technically competent officials.

The idea behind the management committees is to combine a number of hospitals whose services add up to those of a decent gen-

(Continued on page 50)

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"The test of the first 12 years has not shaken the National Health Service, but has instead left it strengthened, causing it to send down deeper roots." This observer notes that "While other factors have contributed to the improving health of the nation, the health program . . . deserves a good share of the credit."

The Health Service: Its First Decade

By ALMONT LINDSEY

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THE NATIONAL Health Service in England and Wales, which had its roots in medical reports, studies and legislation of the preceding decades, was established on July 5, 1948. The framework of the Service was carefully constructed, with due regard to salvaging what was worthy in the old arrangements. Some features were borrowed from the Health Insurance scheme. The local health authorities could not be ignored and the professional groups exerted their share of influence.

The basic conception of the administration of the National Health Service is to decentralize as much authority as possible. Instead of creating a unified system, with all parts completely co-ordinated under central jurisdiction, the National Health Service Law of 1946 recognized three types of statutory agencies, more or less independent of one another. The hospital or specialist service is directly responsible, through the regional hospital boards, to the Ministry of Health. The local health authorities, however, being elected by the ratepayers, are less amenable to the will of the Ministry. Coterminous with the local health authorities are the Executive Councils, which, predominantly elective, are semi-autonomous but still not free of supervisory controls.

The local health authorities, which in

reality are the county or county-borough councils, number 146 and are responsible for such services as ambulance, health visiting, domestic help, home nursing, vaccination and immunization, maternity and child welfare, and after-care. They also operate the health centers, which thus far have played a somewhat limited role in the health program. The 138 Executive Councils are responsible for the pharmaceutical, dental, eye and medical practitioner services. The 15 regional hospital boards and the subordinate 379 hospital management committees (all appointive) administer 2,450 hospitals. In addition there are the teaching hospitals, totalling 150, which are separately administered by 36 Boards of Governors, also appointed by the Minister of Health.

The division of duties between the local and national authorities and between elective and appointive bodies has worked surprisingly well. What the Health Service lacks in flexibility it has gained in the popular support which comes from the participation of thousands of voluntary workers. Through the Executive Councils, the regional hospital boards and the hospital management committees (none of whose members are paid for their services), and the local health authorities, the N.H.S. has achieved a democracy that is perhaps its unique characteristic.

The influence exerted by government organizations has proved beneficial. Such parliamentary agencies as the Public Accounts Committee and the Select Committee on Estimates keep a sharp eye on the hospitals. The primary concerns of these committees are to eradicate waste, to promote efficiency, and to improve standards. The interest of both houses of Parliament in the Health Service is disclosed in high-level debates and, more frequently, in the question-and-answer periods.

THE DOCTOR'S POSITION

The influence of the British Medical Association often has proved so decisive that there seems to be some foundation to the charge that control of the Health Service is weighted in favor of the doctors. Their prestige is constantly felt through numerous bodies. Reference need only be made to the Central Health Services Council (a national advisory body) and the Executive Councils, with their heavy professional representation, or to the groups concerned with the medical practitioner service, such as the local medical committees, the Medical Service Committee, and the Medical Practices Committee. Many doctors are members of the hospital boards and management committees. Virtually every phase of the Health Service that concerns the medical profession has been the subject of discussion between the Ministry of Health and the General Medical Services Committee, which functions as the negotiating agency for the British Medical Association.

Although substantial progress has been made toward a better Service during the first 12 years, some problems do not easily yield to corrective action. The most troublesome one arises out of the tripartite system. No subject has been discussed more avidly than how to achieve better co-ordination between the hospitals, the general practitioners, and the local health authorities. Before 1948, these services were locked in comparatively tight compartments, and in some cases there was even unfriendly rivalry among them. Under the Health Service, a new climate of mutual help-

fulness has slowly begun to emerge, but the over-all picture leaves no room for complacency.

The National Health Service has never lost sight of the importance of the general medical practitioner. Every effort has been made to strengthen this phase of the program. Through financial inducements and the use of negative direction, the government has been able greatly to improve the distribution of physicians. In 1952, the number of people residing in under-doctored areas represented more than one-half of the population; six years later, it was less than one-fifth.

While entrance into general medical practice is not easy, the situation has improved through Initial Practice Allowances and a special "loading" arrangement in remuneration that encourages the establishment of partnerships. The great majority of those entering practice do so as partners. The medical schools have overflowed with students, many of whom are the sons of doctors, and each year has witnessed a healthy growth in the number of physicians.

Although there is competition among physicians for patients (for there is freedom of choice for both doctor and patient), the Health Service has done much to foster professional cooperation. This has been achieved primarily through partnerships, which now embrace more than two-thirds of all principals. Rota schemes, to which over one-half of all family doctors belong, provide more off-duty hours. Group practice, however, has the most to offer in cooperative medicine. Through interest-free loans, the government encourages the establishment of communal premises, so that several doctors can work together as a clinical team.

Compared with their economic status before World War II, the doctors have done significantly better under the Health Service. They are one of the most highly paid groups in England. The absence of suitable machinery to adjudicate differences over remuneration was a major weakness in the Health Service which the Pilkington Commission in 1960 sought to remedy through the creation of the Review Body. This agency

has been authorized to survey periodically the remuneration of doctors and dentists and to propose an adjustment whenever circumstances require it.

The medical profession realized that the straight capitation system of payment encourages work based on quantity rather than quality. The method was accordingly modified by providing an additional payment, or loading fee, for each patient within a fixed medium range. Large lists were discouraged in this way, and doctors with small lists were benefited. While not perfect, the capitation system has worked reasonably well and is preferred to either the salaried or item-of-service methods of remuneration, neither of which ever appeared to have much support.

The average physician does not seem to be overworked. The evidence would indeed sustain this assumption, since the rate of consultations, home visits, and night calls is no greater and is sometimes smaller than existed during the pre-Health Service era. Paper work, involving certification, medical records, prescription forms, and so forth, is not viewed as burdensome by most doctors. Secretarial help eases the clerical burden, and the rota system increases the free time of family doctors. Many of them seldom keep their patients waiting in the reception room more than 30 minutes.

There is no very accurate way to measure the effects which the Health Service has had upon the doctor-patient relationship. If bedside manner and leisurely treatment are the main criteria for judging this relationship, then it can be argued that there has been some deterioration under the Health Service. But the quality and adequacy of the treatment have not suffered under the health program, nor has there been any decline in the doctor's professional or even friendly interest in his patients. The physician is far more effective clinically because he can give patients whatever treatment is required.

The public certainly does not feel there has been any deterioration in the doctor-patient relationship. The Social Surveys (Gallup Poll) in 1962 revealed that nearly three-fourths of the patients interviewed felt that

their doctor took them into his confidence when they were being treated. Over three-fourths believed that their physician was a friend and a confidant, and that he gave enough time for treatment. Eighty-nine per cent expressed satisfaction with the services provided under the National Health Service.

Although a patient can easily change doctors, he rarely does so. While some patients abuse the Service, the vast majority do not. Most patients show a cooperative and understanding spirit. There is little evidence that the Health Service has fostered more hypochondriacs than would normally be found under any other system of medicine; it may have produced fewer. The privacy of the doctor-patient relationship in no way has been imperiled by the new service.

General acceptance of the Health Service by the medical practitioners was clearly shown by the Social Surveys' poll of 1956, in which over two-thirds of the respondent practitioners indicated that if they had a chance to go back ten years they would vote in favor of the establishment of the Service. Even more impressive was the report in 1962 of a non-governmental committee under the chairmanship of Sir Arthur Porritt. Representative of all branches of British medicine, this committee, after four years' study, concluded that "basically the concept of a National Health Service is sound." While recognizing that there was room for improvement, the report found "no evidence that patients receive better services under systems different from our own Health Service." "We are satisfied that the doctor has retained his clinical freedom" and "We have found little substance in the allegation that general practitioners have suffered a loss of status."

THE HOSPITAL SERVICE

In no branch of the Health Program is progress more easily measured than in the hospital service. In matters relating to staff, beds, inpatients, outpatients, new and renovated buildings, and the growth of hospital departments, data is available that permits clear comparison. Not all factors are favorable, but as a whole the picture is one from

which the British people draw great satisfaction.

Most lamentable has been the failure to replace obsolete buildings with new ones. Although conscious of the need to do this, the authorities were at first handicapped by budgetary restrictions, material shortages and inflation. Not until the latter part of the 1950's did the government begin to tackle the problem seriously. The way was then cleared for an expanded building program that would give England and Wales the modern hospitals that are needed.

By the fall of 1959 three new mental deficiency and three new general hospitals had been opened, and nine others, mostly of the latter type, were under construction. Whereas only \$29,680,000 was spent on hospital building in the 1955-1956 fiscal year, the amount available for this purpose in 1961-1962 had risen to nearly three times as much. A ten-year building program announced in 1962 provided for "90 new and 134 substantially remodelled hospitals, as well as 356 other building schemes each costing over £100,000 (\$280,000) which are to make major additions and improvements to existing hospitals."

An achievement of magnitude was the reorganization and integration of the heterogeneous hospital system. The Ministry of Health has sponsored a policy of renovation, equipment modernization, and proper staffing. Even remote hospitals are not neglected. The improvement of all hospitals is reflected in the greatly improved ratio of treatment to beds, the substantial increase in the number of inpatients and outpatients, the drop in the size of the waiting list, and the drastic reduction in the shortage of hospital personnel. It mattered not who scrutinized the hospital service the verdict was one of unrestrained praise for the rising standards and the increased efficiency.

By utilizing most of the unstaffed beds and by shortening the stay for patients, the hospitals were able to accommodate 30 per cent more inpatients at the end of the first decennium. Although waiting lists have declined, they remain noticeably high. Their size,

however, is deceptive since the figures appear to be greatly inflated. There is no period of waiting for an emergency patient, and in London rarely does it take more than 30 minutes to find a bed for a person who requires immediate hospitalization. Admission for non-emergency patients depends upon the department and varies from almost no delay to a delay of several months.

Since the outpatient service is indispensable to good doctoring, the Ministry of Health has encouraged its expansion. Within ten years, the number of specialists increased more than one-third, thus permitting many more outpatients to be treated. Free access to the outpatient service is a vital part of the medical edifice, greatly strengthening the effectiveness of the general practitioner, who can always get the opinion of a consultant for any patient. The use of specialists in the domiciliary service is likewise praiseworthy and has won the commendation of even the sharpest critics of the Health Service. There is no charge and need alone determines who may use the service. A request from the family physician brings the specialist to the home of the patient. The number of such visits has increased impressively, with virtually every specialty being represented.

A phase of the hospital program that deserves special credit is rehabilitation. Increasing use has been made of physiotherapy and occupational therapy in an effort to restore the functional activity of the patient, to teach him to live with his disability and to do useful work. Remedial gymnasts, almoners, and psychiatric social workers are also used in rehabilitation.

MEDICAL RESEARCH

Medical research enjoyed a healthy expansion after 1948, with larger sums of money being made available for this purpose. The Medical Research Council, an independent agency, cooperates closely with the hospitals in their research effort. The viability of British medical research becomes evident from the recent awards of the Nobel Prize to four members of the Medical Research Council.

The hospital service is active in many other areas. A function greatly appreciated by elderly people is the provision of hearing-aids. There is no charge, not even for batteries or maintenance. Other appliances—artificial eyes, arms, and legs, as well as invalid chairs and tricycles—are furnished free. A rapid expansion of the X-ray and pathological facilities ensures that all patients who require a diagnostic examination receive it. Mass radiography by means of mobile units has vastly increased the number of chest X-rays, thereby making it possible for more patients with tuberculosis and other chest diseases to get early treatment. In collecting blood, the hospital service was able to double the number of donations during the first decade.

Progress in the field of mental health was notable under the National Health Service. It sought to provide a new framework in which physical and mental health are joined under a comprehensive program. Mental disorders are viewed in the same way as other types of illness requiring early treatment; and patients are encouraged to seek such treatment on a voluntary basis. The important role of community care and after-care is likewise stressed, and the local health authorities are urged to provide more clinics, hostels, residential homes, and training and occupation centers.

There was evidence of real progress by the end of the first decade. Voluntary admission of mental patients increased rapidly, compared with a sharp drop in the number of those who were accepted on a compulsory basis. Substantially more nurses attended the patients. The steady growth of the psychiatric outpatient departments, the greater use of mental health consultants in the domiciliary service, the establishment of day hospitals, and the more active role performed by the local health authorities contributed to a reduction in the number of beds in the mental hospitals. Better facilities, an improved diet, and new types of treatment greatly modified life in the mental institutions.

The new approach involved social activity and the use of group and occupational ther-

apy. Individuals for whom there once seemed to be no hope were allowed to return home, and for most patients the length of treatment was shortened. The aged, in particular, benefited from the new methods. There was a noticeable decline in the institutional death rate of chronically ill mental patients and a surprising increase in the annual discharge rate of elderly persons. New legislation in 1959 marked an almost complete break with traditional concepts. Compulsory segregation was completely swept away, and mentally disordered persons were now privileged to enter any hospital for treatment on a voluntary basis.

EXPANDED HOSPITAL STAFF

A greatly expanded staff was required to provide proper care for all hospital patients. By the end of the first decade, the medical and the nursing staff had increased by one-third; and the professional and technical staff, other than doctors and nurses, had grown by 50 per cent. While not all hospitals had a full complement of nurses in 1958, the situation was so much improved that understaffed beds had shrunk to a negligible number.

The Ministry of Health and the hospital authorities have never overlooked the fact that hospitals exist for patients. Although conditions are not ideal in all hospitals, a big improvement has occurred under the Health Service. Redecoration of wards, improvement in catering, utilization of bed curtains and ear phones, use of heated food trolleys, and mitigation of noise are examples of what is being done to contribute to a more pleasant arrangement for patients. In a vast number of institutions, life in the wards has become more pleasant, and the personnel have shown a more sympathetic understanding of the patients' needs.

Although associated with the hospitals, the ambulance service is a local authority function. Before 1948 it was disorganized; afterwards it became mandatory for the local authorities and developed into one of the best efforts of the Health Service. The average number of miles per patient was reduced by nearly one-third, and in other ways there has

been greater operational efficiency of the ambulances.

PREVENTIVE MEDICINE

While the prevention of disease and injury is primarily an activity belonging to the local health authority, much depends upon the cooperation of the general practitioner and hospital services. The Ministry of Health is not indifferent to the matter and through nationwide campaigns has done much to educate the people about dental care, mental health, tuberculosis, respiratory infections, the prevention of home accidents, and the importance of immunization and vaccination. A determined and successful battle has been waged against tuberculosis. But there are other preventive phases that should be noted, such as the Welfare Foods Scheme, the effective work done by child welfare clinics, and the periodic medical inspection of school children. Such factors have contributed to the low mortality rate and the good health of British youth.

Health visiting, home nursing, the domestic help service, and the domiciliary midwifery service are of great usefulness among the domiciliary services. The health visitor is concerned with the entire gamut of mental and physical illness while the others are limited in their work. So popular are the home nursing and domestic help phases that they have enjoyed a phenomenal expansion, being increasingly utilized in the care of the elderly and chronic sick. The district nurses are used to administer injections and for general nursing care in the home. They have proved of inestimable value to the general practitioner. The domestic worker does routine work in homes that require such help. Without these two services, many households would have been broken and the patients removed to an institution.

THE AGED

The growing proportion of aged people has dramatized the need to expand some of the health facilities and to adapt them in a more purposeful manner. Most effective in dealing with the problem of chronic illness are

the geriatric outpatient departments and geriatric units in the hospitals. Day hospitals and short-stay convalescent wards or annexes are also of value. Chronic-sick beds have been increased. Improved techniques of treatment greatly expedite the discharge of elderly patients.

The local authorities are involved in many different ways in the approach to the problem of the elderly and chronic sick. Such activities as meals on wheels, a chiropody service, and an evening and a night attendant service are used in some areas with promising results. Of primary importance are residential accommodations. More housing for old people is being erected by the local authorities, the trend being away from the larger institutional approach. Small homes, some newly erected and others remodeled houses, have been opened to the aged.

DRUGS AND OTHER SERVICES

All segments of the population can be grateful for the pharmaceutical, the dental, and the ophthalmic services. Subject to a nominal charge, any drug, regardless of cost, may be obtained from the pharmacist, and doctors are permitted to prescribe freely whatever will most effectively help the patient. This fact, more than any other, has strengthened the doctor-patient relationship and has given the family physician a weapon of incalculable value in curative and preventive medicine. In many ways the pharmaceutical service is one of the most economical of all branches when measured in terms of the amelioration of suffering, speedier recovery, and a lower mortality rate.

The benefits that flow out of the ophthalmic service affect the opticians as well as those who need spectacles. Over 50 million sight tests were given during the first ten years, and most of them involved the dispensing of glasses. Few people in need of spectacles have not obtained them from the Health Service. The most satisfying feature is that no longer do impecunious persons, particularly among the aged, have to wear glasses of dubious value obtained from chain-store counters or street vendors.

The dental profession likewise gained from the Health Service, although it has been plagued with problems that could not easily be solved. In seeking to deal with a serious shortage of dentists, the government has expanded the student training facilities. In spite of the limited dental facilities, the amount of conservative work has enjoyed a gratifying increase. One important aspect constitutes a tremendous boon to the elderly—the availability of dentures. In the pre-1948 era there were those who, unable to afford artificial teeth, went without or had

to use ill-fitting dentures inherited from others. The Health Service made good dentures available to all, free at first and then later subject to a moderate charge.

IMPROVING HEALTH

While other factors have contributed to the improving health of the nation, the health program, it is felt, deserves a good share of the credit. The picture in 1959 (after ten years of the Health Service) had never been better. In that year the infant mortality rate had fallen to 22.2 per 1,000 births, and the maternal mortality rate to 0.32 per 1,000 births—lower than at any previous time. Only in the Netherlands, Sweden and New Zealand was infant mortality less, but no nation had a smaller rate of mortality for children between one and 14 years of age than England and Wales. In that year, for the first time, no one died from diphtheria, and deaths from such diseases as acute poliomyelitis, scarlet fever, tuberculosis, whooping cough, syphilis, and acute rheumatism were the lowest ever recorded.

The test of the first 12 years has not shaken the National Health Service, but has instead left it strengthened, causing it to send down deeper roots. Many weaknesses have been eliminated or reduced, and others are being acted upon by a government that has improved its fiscal position. No longer does England have doubts as to whether the economy can afford such a comprehensive scheme. Prudent spending and careful management have produced a service of incalculable value.

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Almont Lindsey is the author of several magazine articles and *The Pullman Strike: The Story of a Unique Experiment and of a Great Labor Upheaval* (1942). He spent six months in England for his book, *Socialized Medicine in England and Wales: The National Health Service, 1948-1961* (1962). In addition he devoted many years to a careful survey of the vast amount of literature on the subject.

"The justification of the present system of financing the National Health Service is . . . that it allows the rational provision of services, and that it extends medical care to the particularly vulnerable groups in the community. . . ." In addition, this economist believes that "finance through general taxation is the cheapest to administer."

Cost of the National Health Service

By GORDON FORSYTH

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THE ACID test of any medical care system is the protection it gives to the chronically sick—those with long-term mental or physical illness who increase in number as man's average life-span increases in years. It invariably happens that the nature of their handicap renders these people the least able to pay the costs of their treatment. In Britain we have taken the view that in consequence a comprehensive medical care system has to be financed through general taxation. In this way, if the tax system is fair, the heaviest burden is placed on the broadest shoulders and access to medical services is made to depend on need and not on the ability to pay for them. In the last financial year for which figures are available (1961) over 70 per cent of the total Health Service costs were met by the central government out of general taxation as Table I shows. (See page 20.)

Of the £626 million contributed by public authorities by far the largest amount—£559 million or 69 per cent—was paid directly by the central government. Of the rest, £33 million was paid by local government authorities and derived from local taxation, which in Britain is based on house values. The local authorities spent this money on the services they are compelled to provide, such as health visiting, district nursing, maternity

and child welfare services, and for which they receive equivalent grants from the central government. This means that in all the central government contributed £592 million or 73 per cent of the total Health Service expenditure.

The £102 million received by the Health Service in the form of National Insurance contributions merits special mention since the reform of health services in Britain was closely linked with wider reform of the general social security system stimulated by the celebrated Beveridge Report of 1942. Adequate and freely available medical services were seen as a cornerstone of social security, an important element of which was to be compulsory insurance against such hazards as unemployment, widowhood, and incapacity to earn one's living because of old age. The present system is compulsory for everyone (except married women) between school leaving-age and retirement and confers benefits such as unemployment pay, maternity grants and payments to widows. Although access to the National Health Service does not depend on these insurance contributions—all you need do to qualify for the N.H.S. is to be in Britain, even citizenship does not matter—nevertheless part of the insurance contribution includes an item for the Health Service. Tables II and III show the

TABLE I
Sources of N.H.S. Finance 1961 (England & Wales only¹).

Source	£ million	Percent.
Public Authorities	626	77.
National Insurance contributions	102	13
Fees charged to patients	36	4
Other	45	6
	<u>809</u>	<u>100</u>

(Ministry of Health Annual Report 1961)

¹ There were separate Acts of Parliament setting up Health Services in England and Wales and in Scotland. Principles of financing these services are the same but there are important differences in administration. English people sometimes say Scotsmen run the Scottish Health Service better than Scotsmen run the English Health Service!

structure of these payments, how they affect the individual and the share given to the Health Service. (See page 21.)

Thus the average Englishman pays about £30 or \$84 each year for his social security, which includes about £8 or \$22 each year towards the National Health Service. In the past such payments have represented about 13 per cent of the total N.H.S. income; the above rates were introduced in 1962 with the intention of raising the insurance element to about 17 per cent of total income.

Only four per cent of the Health Service's income came from fees paid by patients using the Service. This £36 million was made up as follows:

	£ million
Charges for Drugs	12
Dental treatment	10
Ophthalmic appliances	7
Fees in hospital	7
	<u>36</u>

Drug charges are not levied on hospital patients and the above £12 million represents payments made for prescriptions issued by family doctors. The patient pays two shillings (about 28 cents) for each item prescribed, irrespective of its cost. The chemist is paid by the state the total net ingredient cost of the items he supplies, plus a 25 per cent retail mark-up and certain fixed dispensing fees. Dental treatment is free to children and expectant mothers and the rest of us pay about \$2.50 or the cost of treatment

whichever is the lower. Fees in hospital relate to private beds, which are charged for at the rate of about a dollar a day. Where it is medically desirable, of course, patients may be placed in a private room without paying anything.

CRITICISM AND COMPLAINT

The British National Health Service is thus free for about 96 per cent of its total cost in the sense that patients generally do not pay for the service as they use it. Payment for the service is made overwhelmingly through general taxation. There has of course been continuous opposition from those who (on political grounds) are against financing the N.H.S. this way, but criticism has hardly been consistent. In the early years of the service the cry was often raised that the method of finance encouraged waste and inefficiency and led to too much expenditure on health. More recently, the complaint has been that the present system has led to too little being spent on health.

Complaints about abuse of the service and overspending became so rife in the early 1950's that in 1953 the Conservative government set up a committee of enquiry to find out what was going on and to recommend how to avoid what was felt to be a steadily rising burden on the Exchequer. To everyone's surprise the Guillebaud Committee report of 1956 (Cmd. 9663) demonstrated beyond question that far from squandering the taxpayers' hard-earned cash through ineffi-

TABLE II
National Insurance: Main Rates of Weekly Payments.

	Men aged		Women aged	
	18 or over	under 18	18 or over	under 18
Employed persons:				
Paid by employee	11s.8d.	7s.8d.	9s.8d.	6s.4d.
Paid by employer	9s.8d.	7s.0d.	8s.4d.	5s.7d.
Total	21s.4d.	14s.8d.	18s.0d.	11s.11d.
Self-employed persons:	16s.2d.	9s.1d.	13s.2d.	7s.9d.
Non-employed persons:	13s.0d.	7s.4d.	10s.0d.	6s.0d.

ciency and overspending, the Health Service, when its cost is related to the national income, has cost less and less each year. In its first full year of operation (1949-1950) the service cost nearly £372 million or 3.75 per cent of the gross national product: by 1953-1954 the cost was £430 million or 3.24 per cent of the gross national product. Since then the costs have remained fairly stable at about three per cent of the national income—roughly equal to the amount we spend on tobacco and cigarettes and only half the amount we spend on defence. Although the costs have been relatively stable, there has been a steady increase in the amount of work done. The hospitals, for example, with only a six per cent increase in the number of beds at their disposal, admitted 4.3 million patients in 1961 compared with 2.9 million in 1950, an increase of 48 per cent. During the same period, the number of new cases treated on an ambulatory basis rose from six to seven million. Many industrial corporations would be pleased to attain such increases in productivity!

No longer able to say that financing the Health Service through general taxation leads

to reckless extravagance with public funds, the opponents of collective action through public finance have changed their tack in recent years and now say that the system prevents consumers from spending as much as they would wish on health care services. The liberal economists who argue this way, principally D. S. Lees in *Health through Choice* and J. and S. Jewkes in *The Genesis of the English Health Service*, have not been taken very seriously in Britain. All political parties recognise that a major departure from the present system is socially undesirable and politically unacceptable. In the United States, however, the works of Dr. Lees and Professor and Mrs. Jewkes have received the widest publicity, so that although in an English journal they would merit only a footnote, here their main criticisms must be answered in some detail.

SPENDING FOR HEALTH

There are three foundations to the belief that more would have been spent on the Health Service under a system of private pay or voluntary insurance than has been spent under the present system.

TABLE III
National Health Service Contributions.

	Men aged		Women aged	
	18 or over	under 18	18 or over	under 18
Employed persons:				
Employee pays	2s.8½d.	1s.4½d.	2s.0½d.	1s.4½d.
Employer pays	7½d.	7½d.	7½d.	7½d.
Total	3s.4d.	2s.0d.	2s.8d.	2s.0d.
Self-employed and non-employed persons	3s.2d.	1s.10d.	2s.6d.	1s.10d.

(i) The United States, with a system of voluntary insurance and private finance, has devoted in recent years about six per cent of her national income to medical care services compared with less than four per cent in Britain.

(ii) This has led to the "discovery" that medical care has "a high income-elasticity" of demand, that is, as incomes rise proportionately more money will be spent on health care (unless this is prevented by a system of public control).

(iii) It is assumed that the objective of the medical care system is the "maximisation of consumer satisfaction" and consumers express their satisfaction by spending money on the things they want.

These statements seem plausible until the wider issues are taken into account. It is true, as far as comparisons of national income and expenditure are valid, that the United States devotes a larger share of the national resources to health than we have in Britain. Why then is the federal government so anxious about the comprehensiveness of American services and so desperately worried about the 17 million elderly Americans excluded by the present system? One country devotes four per cent of the national income to health and achieves a more comprehensive system than a country which devotes six per cent of its national income to health. Which system should economists applaud?

It is true that "medical care has a high income-elasticity of demand." We all know that people who cannot afford medical care go without it. This of course was the bitter experience of the British in the depression of the 1930's. No doubt the liberal economists would argue that today's services should be based on today's conditions. They point out, rightly, that not only the poor have benefited from the National Health Service. The newly-affluent English middle classes have also benefited, particularly from nationalisation of the hospitals.

Before the war, public hospitals existed for special groups. For the aged poor there were the dreaded workhouse infirmaries, the places where poor people went to die. There

were lunatic asylums for the mentally sick and defective. There were maternity hospitals for expectant mothers and isolation hospitals for those with infectious diseases. The rich had their private nursing homes. But for the middle classes, unless they were mad, pregnant, or suffering from infectious disease, there was nothing save for a few general hospitals built by progressive local authorities under permissive legislation of 1929, or the voluntary hospitals, where care could be had on a charitable basis.

The voluntary hospitals included the great teaching institutions, some of them dating back to medieval foundation, endowed with great wealth and resources. They were however unevenly spread about the country, with 26 in London and only 12 in the provinces. The rest of the voluntary hospitals were in a sorry state. Staffed largely by unqualified surgeons, they had fallen on hard times in the 1930's as costs increased under the impact of scientific medicine. Many were dilapidated and short of equipment. It has been estimated that if they had been left to their own resources after the war they could have stayed open for 10 weeks at most.

Under the National Health Service Act of 1946, responsibility for all types of hospitals—with the exception of a few specifically disclaimed nursing homes—became vested in the Minister of Health in 1948. All hospitals were radically affected by the change. For example, one former local authority mental hospital, whose patients before the war could expect on average only four hours of individual attention each *per annum* found itself cast as the regional centre for four million people, adequately staffed for the first time, and associated with peripheral clinics, each with a team of skilled psychiatrists. Former poor law infirmaries became chronic sick hospitals with their first specialist staff. Doctors in sufficient numbers could now earn a living in all parts of the country by specialising in the hitherto unremunerative fields of psychiatry and geriatrics.

But of all changes those in the voluntary hospitals were the most sweeping. They became part of a large-scale organization,

were guaranteed adequate funds, and acquired the services of specialist surgeons and physicians. In turn, the middle classes, the chief occupants of these upgraded cottage and voluntary hospitals, can be said to be the chief beneficiaries. The liberal economists argue that with their new-found affluence the English middle classes would be willing, if allowed, to spend much more on health care, thus raising the proportion of national income devoted to medical services. In a free market, consumers would then be able to "maximise their satisfaction." But what does this mean? If it means the freedom of patients to determine the amount of medical care they need and can afford then not only would it lead to gross inequalities but also to waste of medical skills and resources. The present system has freed the doctor from economic dependence on the over-demanding patient. And in this context it is relevant to recall the comment by Dr. Esselstyn of the Rip Van Winkle Medical Centre: "The medical profession is not sufficiently mature to resist the temptation of unnecessary procedures inherent in the fee-for-service system."

A better interpretation of "maximisation of consumer satisfaction" is possible, however, although it is one the liberal economists have failed to appreciate. People have needs in addition to the need for health care: education for their children, provision for their old age, good transport and a host of other public services and utilities. To satisfy the demand for this complex of services requires the planning or rationalisation of their provision. If needs, as opposed to demands, can be met at a lower cost under public control than under private, money saved on health can be used for housing, education, defence and so on. To complain therefore that public ownership has reduced health expenditure from what it would have been under a privately-financed system is to complain that the N.H.S. has achieved one of the things it set out to achieve.

Here, incidentally, lies the answer to the most frequently voiced criticism of the National Health Service, that no new hospitals

were built until it had been in operation for ten years. No new hospital was built simply because, as a deliberate act of policy, scarce building resources were used to construct houses and schools in that order of priority. Now, however, the Health Service is engaged on a massive hospital building programme, costing some \$1.5 billion over the next decade—reconstruction on a scale unthinkable under an insurance or private pay system.

JUSTIFICATION FOR TAX FINANCING

The justification of the present system of financing the National Health Service is, therefore, that it allows the rational provision of services, and that it extends medical care to the particularly vulnerable groups in the community who, unless possessed of some wealth, would be deprived of the services they need, or become a heavy economic burden on their families. One other aspect deserves attention: finance through general taxation is the cheapest to administer. As Herman and Anne Somers have pointed out in their excellent book, *Doctors, Patients, and Health Insurance*, (Brookings Institution), the costs of collecting premiums under insurance systems often amount to as much as thirty cents in every dollar. In Britain the cost of raising the money is merely the cost of running the Inland Revenue—a mere one and a half cents in the dollar. The present system is not just socially sensible: it is economically sensible as well.

Similar considerations apply to an aspect of the Health Service which its opponents have found particularly irritating. As noted earlier, the sole qualification to benefit from the Health Service is residence in Britain (the last time Bob Hope appeared on British television he began by saying: "It's nice to be back—and besides my teeth needed fixing.") It is not only tourists and visitors who are welcome to use the service on the same footing as the British. It has happened on occasions that people in need of expensive surgery have been flown to Britain, the cost of the flight being less than the cost of the operation in their own country. Thus

Italian villagers have collected the air fare for a poor child in need of cardiac surgery. This of course is only possible because the Health Service is based on general taxation; it could not happen under an insurance system.

There are three advantages from the British point of view: firstly, this is a fine advertisement and must win us many friends in Europe at a time when we need them. Secondly, the costs of recovering money from casual patients would exceed the costs of treating them free of charge. And thirdly, because we make our services freely available to visitors to our shores, it has been possible to negotiate reciprocal arrangements with a few other European countries, so that British tourists in France and Scandinavia can enjoy the same facilities, should they need them, as the native French or Scandinavians.

PROBLEMS OF THE N.H.S.

It should not be inferred from all this that the National Health Service is free from problems. On the contrary, there are many and varied difficulties. Many of them, however, can only be tackled within a comprehensive framework based on a system of consolidated finance. For example, it has been easier in Britain under the present system to place the responsibility for mental health squarely on the community, with the emphasis on active treatment in a normal environment as opposed to custodial care in some remote barracks of an asylum. The Ministry intends to reduce mental hospital beds from the present 3.3 per 1000 population to 1.8 per 1000 with greater responsibility thrown on local community services. Whether the relationships involved will, in fact, allow such a dramatic reduction remains to be seen but at least it is now possible to experiment regionally and nationally.

The present system of finance, however, produces its own problems, one of the most difficult being the impact of public accountability. That public servants entrusted with public funds should give an account of their disposal to the public's representatives is a feature of all democratic governments.

In Britain we had to cut off a king's head and fight a civil war to establish the principle. The trouble is that British budgetary allocations are made strictly on an annual basis; any funds which have not been spent by the end of the financial year on March 31 revert to the Treasury. One effect on the Health Service is that hospital authorities, round about February, begin eagerly searching for ways to spend remaining balances; this is clearly not in the interest of economy with public funds. It is easy to see the hospital managers' point of view. If they do not spend the money it must be handed back and this may mean a reduced allocation the following year. It would be better if they could be allowed to carry forward unspent balances to the next year. But so far efforts to enact this reform have been strongly resisted by Parliament, anxious to maintain the constitutional principle of public accountability and jealous of its power to control the executive by keeping a tight hold of the purse strings.

Meanwhile, great efforts have been made within the hospital service itself to ensure that resources are used wisely. A highly sophisticated costing system has been developed and has helped to give a better understanding of why the costs of running hospitals have increased so rapidly (a situation common to all countries, including the United States). The British hospitals are labour-intensive rather than capital intensive and this is inevitable as long as medicine re-

(Continued on page 51)

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Discussing the role of the physician and the state of medical care in Britain, this author observes that "the physician . . . enters practice well grounded in the idea of comprehensive medical care and is able to use the other members of the medical social team to the patient's advantage."

The British Doctor

By FREDERICK J. SPENCER

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A NEW GENERATION of doctors is emerging in Britain. This group knows only one system of practice—the national Health Service. The "old soldiers" who fought Aneurin Bevan are "fading away" and their successors, recently graduated, are more tolerant of the shortcomings of the service.

Any doctor who is licensed to practice medicine by the General Medical Council may practice in the National Health Service. Before his name is entered in the Medical Register, however, a doctor must satisfy the General Medical Council that he is competent to practice medicine. This is usually done by passing the examinations in medicine of one of the British universities, which award the degree of Bachelor of Medicine, Bachelor of Surgery (M.B., B.S.).¹

In England, the Royal Colleges of Physicians and Surgeons are also permitted to award degrees in medicine, the successful candidate becoming a Licentiate of the Royal College of Physicians, Member of the Royal College of Surgeons (L.R.C.P., M.R.C.S.). A similar degree is granted by the corresponding authorities in Scotland. A third method of becoming licensed by the General Medical Council is to pass the examination of the Society of Apothecaries. The degree obtained,

Licentiate in Medicine and Surgery of the Society of Apothecaries (L.M.S.S.A.), is the most uncommon in Britain, the majority of doctors being graduates of one of the universities. Some general practitioners have higher degrees in medicine, surgery, or obstetrics, although the vast majority do not proceed beyond their required one year of internship and possibly one or two years as a registrar (resident).

The student spends five years in medical school while training. Only one additional year of pre-medical study is required as a result of the level of education in the British public or grammar schools. Generally, European educational methods concentrate on teaching pure academic subjects, and it is not unusual for the time between 16 and 18 years of age to be spent in studying science for the greater part of the time in school. Thus the pre-medical student already has a good grasp of the chemistry, physics and biology that are his subjects of study. Students often enter medical school directly from high school, as exemption from the pre-medical examination may be granted if the entrant's grades justify it.

The usual method of entering practice is to be employed as an assistant with a view to partnership. The partnership materializes in a varying number of years, sometimes within a year or two and sometimes not for a considerable time. Trainee assistantships are

¹ Some universities use the old form of "Chirurgie" in their degrees—hence M.B., B.Ch. or M.B., Ch. B.

available in which the general practitioner is subsidized by the government for employing an assistant. These trainee assistantships are sometimes abused, the assistant being used for the more menial duties of general practice and kept in this position for years without any advancement towards partnership. Some 70 per cent of general practitioners in Britain are in partnership or have an assistant, thus allowing ample time off for even the busiest doctor.

There are some limitations upon the location of new practices. The Ministry of Health has designated certain areas as having an adequate number of doctors to serve the population, and no new practice may be located in these places. Conversely, other regions have been listed as "under doctored" and practitioners are encouraged to settle in these locations by the offer of financial inducements. All new practices must be approved by the Local Executive Council.

DOCTOR-PATIENT TIE

The greatest thorn in the flesh of the general practitioner is undoubtedly the size of his practice. The maximum of 3,500 patients, permitted by law, is too high. It is even questionable whether the "list" of 2,500 patients proposed by the 1959 Labor government would allow the general practitioner to practice the type of medicine which was envisaged by the founders of the National Health Service. The fact that less than one-third of practices reach the 3,500 maximum is no excuse, as more patients mean more money. The doctor therefore strives to increase his income by expanding his "list" and forces himself to provide more consultations per unit of time. Thus the pattern of more patients and less time in which to see them is established.

In considering the doctor patient ratio, however, it must be remembered that most general practitioners in Britain rely upon the traditional European method of clinical diagnosis by the five—or rather four—senses, largely to the exclusion of laboratory tests. This means that less time is needed to examine the patient and explain the findings

to him. Despite this, a reduction in his "list" would be welcome to the British general practitioner, provided, of course, that the necessary upward adjustment was made in the patient capitation fee. This is unlikely to occur in the near future with the present annual number of medical graduates.

It has been repeatedly stated that a large number of British doctors are emigrating to greener pastures. Statistics on this phenomenon are very unreliable, but in 1962 the Minister of Health referred to this as an "exploded myth." Although it is probably true that the net emigration has increased only slightly since 1947, there may well have been a change in the proportion of specialists or potential specialists among the emigrants. Dissatisfaction with the time required to reach consultant status has certainly produced a restlessness among British registrars which increases the attraction of emigration.

It is unusual for the British physician to enter his surgery (office) before 9:00 A.M. If he lives away from the practice premises he may make one or two home visits on his way to work, especially if he has received an early call which can be dealt with in this manner. Usually his morning consultations will occupy from one to one and one-half hours, but the allotted time will be extended by having to see those patients who are in the waiting room when the door is closed at 10:00 or 10:30 A.M. During morning surgery hours 15 to 30 patients may be dealt with. Many of these take up very little of the doctor's time as they only need repeat prescriptions or medical certificates.

It is customary to ask patients who require home visits to call before 10 A.M. This allows the visiting list to be compiled over the traditional cup of tea which follows the morning surgery. If the practice consists of a partnership or includes an assistant, this time is also spent in discussing patients and other routine practice matters. The mail, consisting mainly of advertisements and consultants' reports, is dealt with either before or after the surgery. In small practices, the doctor's wife may act as a secretary, but usually a secretary-receptionist is employed.

The number of home visits made by the British practitioner varies widely, but it is customary for 10 to 20 patients to be seen each day. In an influenza epidemic this may increase to 30 or even more visits. These winter epidemics of respiratory diseases tax the practitioner to his utmost capacity. The evening surgery begins at 5:00 or 5:30 P.M. and continues for two hours. Some 25 to 40 patients are seen during this time. One or two house calls may be made on the way home. Thus the British doctor has a full day.

The amount of private practice in which a doctor indulges is up to him. Some physicians consider private patients are not worth the time spent upon them in extra bookkeeping, while others do not accept any National Health Service patients. Although there has been an increase in patients with private medical insurance since 1947, the 2 per cent of private patients in Britain today is negligible, most of them being concentrated in the few niches of the "affluent society" which still persist in nationalized Britain.

Night calls are, on the whole, not too numerous, although many British doctors will contest this statement. The subjective view of a doctor who is routed out of bed is inclined to magnify the number of calls, particularly when this has not been arrived at by statistical methods. Valid estimates made by general practitioners have set the annual number of night calls at 15 to 20 per 1,000 patients. This of course may be doubled where the doctor has an active obstetrical practice.

MIDWIFERY

Before a general practitioner may indulge in domiciliary midwifery (obstetrics), his experience is reviewed by a committee of the Local Executive Council, consisting usually of a consultant, two general practitioners with obstetrical experience, and a Medical Officer of Health—all doctors. With the approval of this committee, the doctor may include obstetrics in his practice. This method of selection was introduced to ensure that only competent general practitioner-obstetricians would practice midwifery.

Home care and delivery of the pregnant woman is still common in British medical practice, over one-third of the deliveries in England and Wales in 1961 being performed in the home. The doctor is greatly helped by the midwife who is a graduate nurse with postgraduate training in midwifery. She is required to pass an examination before entering practice, which she does as a State Certified Midwife (S.C.M.). She is a highly skilled individual and is completely competent to deal with normal deliveries without any assistance. She is allowed to use the patient-administered type of gas inhalation analgesia, but must call in a doctor for the minor tissue repair which is sometimes necessary following birth. She provides complete prenatal care and visits the patient at least once a day for 14 days after delivery.

The practitioner is therefore relieved of the routine prenatal and postnatal visits which can be so time-consuming. In some instances, the midwife alone follows the patient through pregnancy and delivery. Usually, the doctor is "booked" for the pregnancy, although he may not always attend the delivery. Often the doctor may be present at the birth, merely administering a light anesthetic and allowing the midwife to perform the actual delivery.

It has been said that much of the doctor's work in Britain consists of filling in forms, but of some 35 different forms pertaining to general practice, only three are regularly used:

1. The prescription form.
2. The medical certificate which is required for payment of benefits to the patient. In most instances this must be renewed weekly while the patient remains out of work.
3. The individual medical record in which a notation is made after each patient's visit. One advantage, greatly appreciated by the doctor, is that the patient's medical record goes with him wherever he may move. Consequently it is always possible to obtain a complete past history on any new patient without submitting him to tedious questioning. One aspect of form filling is not regarded with hostility by the British physician. In many instances, besides the National

Health Insurance form, patients request a note certifying their absence from work because of illness. This is given to their employer. As this form does not come within the structure of the service, the doctor is allowed to charge a small fee for it.

SPECIALIZED CARE

A factor in the National Health Service which is most welcome to the general practitioner is the ready availability of the consultant's opinion. This is generally obtained by sending the patient to the out-patient department of a hospital, but domiciliary consultation may be had at any time. This service is extensively used and the physician is freed of the burden of deciding whether the patient can afford the consultant's fee, which is paid by the National Health Service. Patients will sometimes request a private consultation and this is arranged by the general practitioner, the specialist's fee being paid by the patient.

Doctors in Britain refer many patients to hospital out-patient services, particularly as most general practitioners have neither the skill nor the facilities for attending to more than the most minor surgical conditions or performing the most elementary laboratory tests. The temptation which presents itself to the busy general practitioner of using the out-patient department for even minor surgery, e.g., the suturing of superficial lacerations, is not always easy to resist. The increasing role of the laboratory in medical diagnosis has also contributed to the pattern of referral which has become firmly established in current British medical practice.²

One geographical factor is often forgotten in considering British medicine. Britain is a small country with the population concentrated in urban areas. Because of this, well-equipped and staffed medical centers are readily available to the general practitioner. Apart from remote areas such as the Western Highlands of Scotland, consultant and other

specialized services can be reached by the patient with a minimum of time spent in travel. This proximity of consultants to the general practitioner therefore promotes ready referral of patients. The patient's welfare is also catered to by the provision of transportation in the form of ambulance services. These are intended for those patients who are unable to use public transportation, although some abuse definitely occurs.

In the out-patient departments, appointment systems keep the waiting period to the lowest possible time. Thus it is unusual for a patient referred to an out-patient department to be away from home for an undesirable length of time, even when he has to travel 50 to 100 miles to the hospital. Many small hospitals, i.e., those outside the teaching hospitals of medical schools, are served by the teaching hospital consultants. When this is not so, the hospital has its own fully qualified specialists who are available for out-patient or domiciliary consultation. Unfortunately these excellent consultant services have not decreased the waiting lists for hospital admission for non-emergency cases, the number of hospital beds negating the availability of specialists to staff them. Awareness of this has prompted the Ministry of Health to launch an ambitious building program.

It is estimated that 25 per cent-30 per cent of patients seen in general practice present psychosomatic symptoms. Many of these patients can be dealt with by reassuring them and prescribing a mild sedative or tranquilizer, thereby helping them to overcome temporary stress. More infrequently, a true psychoneurosis or psychosis may be evident and it is often in the general practitioner's surgery that the potential suicide case may be detected. The necessity of prompt and competent psychiatric help is therefore of the utmost importance. In Britain, perhaps more than anywhere else in the world, vast changes have taken place in handling the mental patient. The use of the open hospital, the day treatment center, and other new techniques in mental health have received the support of Parliament in the Mental Health Act of 1959. Out-patient psychiatric care is used

² A series of papers entitled "Views of General Practice" appeared in *The Lancet*, Nos. 7271 to 7277, January and February, 1963, which presents a picture of current general practice in Britain and the United States.

extensively by general practitioners and, as with organic disease, domiciliary consultation is readily available at no further cost to the patient.

Under the National Health Service Act, the patient has the right to choose whichever doctor he likes. This, of course, is modified by the fact that a practitioner with a full list of 3,500 patients cannot accept any more patients. In addition, choice of doctor, as in any country, is governed largely by the geographical location of doctor and patient. No doctor would think of accepting a patient who lives 50 miles beyond his practice even though some patients request this service. It may be seen, therefore, that in Britain the patient may choose any doctor within the geographical area in which he practices, although, as already stated, the size of the doctor's list may preclude acceptance. On the other hand, a doctor may refuse to accept a patient, although, naturally, any emergency treatment which may be necessary must be administered. The practitioner may also inform a patient that he can no longer treat him. When this is done, however, the doctor is required to continue treating the patient for a further month at the end of which time the patient must have registered with, and been accepted by, another practitioner.

Patients have the right to complain to the Local Executive Council if they think that a breach of professional conduct has occurred. This is extremely uncommon, and the doctor is usually exonerated of blame when he presents his case to the Council. It is felt by a few physicians that this is a somewhat one-sided privilege, the patient being allowed to register complaints against the doctor while the doctor must accept any infringement of his practice by the patient without recourse to arbitration. Most practitioners, however, accept the present situation as conforming to the ethical standards honored by the medical profession.

Another aspect of legal medicine which enters into the doctor patient contract is that of malpractice. The number of malpractice suits in Britain is comparatively small, partly because the patient can turn to the Local

Executive Council for help and partly because litigation is foreign to most members of the British Isles. The cost of malpractice insurance in Britain is therefore negligible—a matter of £2–£3.3s. (\$5.60–\$8.82) per year. It is generally thought by doctors in Britain that the number of lawsuits is increasing, although it is not easy to substantiate this impression. The availability of free legal aid and the idea that the Ministry of Health, as a government department, is being sued rather than the doctor may have contributed to more litigation.

The Ministry of Health imposes some restrictions upon the prescription of drugs, the aim being to use the cheaper non-proprietary medicines. It is interesting to note, however, that the traditional "bottle of medicine" dropped from 34 per cent of the total prescriptions in 1949 to 14 per cent in 1961, while proprietary preparations increased from 16 per cent to 58 per cent. The Ministry has the right to question the doctor about his prescribing methods if his costs run consistently above the local average.

Most British doctors are members of the British Medical Association. There is, however, another professional organization which is becoming increasingly influential in determining the role of the general practitioner in British society. This is the College of General Practitioners, founded in 1952 to promote good general practice. As some three-fourths of the doctors in Britain are general practitioners, the College obviously represents the largest group within the profession. The College now has over 4,000 members and its aims are similar to those of other general practitioner organizations except for one important addition—its sponsorship of research.

MEDICAL RESEARCH

A vast and increasing amount of medical research is being conducted throughout the world today but most of the diseases being investigated are seen mainly in hospitals or other institutions. There are very few accurate data available on the common diseases treated by the general practitioner without

hospital referral. The aim of the College of General Practitioners is to stimulate research into the natural history of these common diseases. Historically, this is no innovation in British medicine.

The first "collective investigation" recorded in England was that performed by John Fothergill, the famous Quaker doctor, during the influenza epidemic of 1775. This was repeated by other physicians during the 1782 and 1803 influenza outbreaks. In 1880, the British Medical Association established a Collective Investigation Committee which published 5 reports before disbandment in 1888.

Thus the College of General Practitioners did not create a precedent when it formed its Research Committee to assist general practitioners. Large numbers of cases of selected diseases throughout the British Isles have been collected and relevant information obtained on their distribution and other epidemiological and clinical data. This method of research contributes considerably to the enjoyment of his practice by the participating doctor. In addition, the College advises individual practitioners upon research within their own practices. Some important contributions have already been made to the understanding of those commonplace diseases which nevertheless produce the greatest amount of illness in the human population.

The interest of the British general practitioner in research may be accounted for by the fact that few academic positions are available. The "research cult" of the medical school therefore spills over into the ranks of general practice, and many general practitioners under different conditions would probably have become members of a medical school faculty. These general practitioners eagerly embrace the idea of research in general practice and their interest kindles the fire in their less enthusiastic colleagues.

The relationship of the practicing physician to the Public Health Department is generally good throughout the National Health Service. The history of modern public health began in England with the efforts of a lawyer, Edwin Chadwick, to clean up the environ-

ment during the cholera pandemics of the early nineteenth century. The traditional acceptance of the Public Health authorities by the British Medical Association which was engendered then continues today. This does not mean that relationships between medical officers of health and general practitioners have been uniformly good for a century. Disagreement, sometimes verging on hostility, has occurred, but generally the attitudes of the two groups have been those of apathy rather than antagonism. The cooperation of the practicing physician and the local health authority is being further cemented by the revised courses which are in effect in many British medical schools.

The teaching of preventive medicine has changed radically since World War II. Increasing emphasis is being placed upon the social, economic, cultural, and behavioral factors in disease production and the methods that may be used to combat them. The days of a course in sanitary science are numbered. The social services provided by the National Health Service are emphasized in the teaching of medical students, the duties of the Health Visitor (public health nurse), home help, district nurse, midwife, and other ancillary medical personnel. The physician therefore enters practice well grounded in the idea of comprehensive medical care and is able to use the other members of the medical social team to the patient's advantage.

One exciting development in British medical practice is the use of Health Visitors working directly out of the general practitioner's surgery. This is being tried in several areas of Britain and results, although not uniform, are encouraging. The Health Visitor is trained in the principles of public health and preventive medicine and is therefore able to assist the practitioner in presenting the social aspects of disease to his patient. Although Health Visiting originated to promote good maternal and child health, the duties of the Health Visitor now encompass all aspects of medical care.

THE DOCTOR'S INCOME

The question of the doctor's income is

complex in that it is clouded by the many additional sources of remuneration which are available to him.³ A practitioner with a full list of 3,500 patients can receive a gross amount of £4,252/10s. (\$11,907). This consists of the capitation fee of 19s.6d. (\$2.73) and the extra "loading" payment of 14s. (\$1.96) which is allowed for 1,200 of the total number of patients. The Ministry of Health average net income figure of £2,425 (\$6,790), upon which the whole structure of general practitioner remuneration is based, does not really take into account the variability in practice expenses.

The present method of payment naturally encourages the doctor to keep his expenses to an absolute minimum, sometimes leading to inadequate premises and other facilities. With a list of 2,500 patients, for instance, the doctor's income would be £3,277/10s. (\$9,117), leaving him only £852/10s. (\$2,387) for expenses. This is completely unrealistic when it is realized that this sum barely suffices to pay a secretary-receptionist's salary.

Additional income may accrue from participation in private, industrial, or insurance practice, and it is also legal and ethical to charge fees for certain services to other government financed persons or agencies, e.g., dentists, local health authorities, pension boards, armed services. Access to these sources is by no means evenly distributed, some practitioners making practically no extra money in this manner. The principle therefore remains that the government does not cater to the practitioner with few patients and no additional income.

In all fairness, however, it must be stated that the government does provide supplementary payments to doctors practicing under varying conditions. These include allowances for doctors setting up in single-handed practices and for those who are practicing in unattractive or sparsely populated areas, mileage allowance in rural areas, reimbursement on

a capitation basis for drugs and appliances supplied by the physician, allowances for the employment of a trainee assistant, and of course fees for practicing domiciliary obstetrics. Nevertheless, there is a considerable amount of dissatisfaction with the method and amount of remuneration.

All doctors must participate in the pension, or superannuation, scheme which is contributory in type, the doctor paying 6 per cent of his remuneration, the employing authority 8 per cent plus a supplementary contribution of 1.5 per cent. The main benefit is a retirement pension at the age of 60 based upon income. This scheme has been well received on the whole, although like remuneration, doubts are expressed from time to time on the amount of the benefits designated.

The consultant in the National Health Service is justifiably more satisfied than his general practitioner colleague, his salary ranging from £2,550 to £3,900 (7,140-\$10,920) with extra "distinction" awards from £750 to £4,000 (\$2,100-\$11,200). The fees paid by the National Health Service for domiciliary consultation increase his income, as do private patients' fees, most consultants being active in private practice. The lack of practice expenses which is enjoyed by some consultants, e.g., pathologists, also contributes to the value of the salary. There is, however, a considerable amount of discontent pertaining to the appointment of consultants, largely because of the few vacancies which occur in this group.

The medical student who wishes to specialize must look forward to many years serving as a registrar with a comparatively lower salary and the added uncertainty that he may never become a consultant. The lack

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³ The 1963 edition of the British Medical Association's *Members Handbook* devotes almost one-fourth of its 208 pages to the section entitled "Fees for Part-Time Medical Services."

Dr. Frederick J. Spencer was a general practitioner in the British National Health Service for three years. He has also worked in private practice in this country. In addition, he has had several years experience in public health, in both local and state health departments.

"It may be fairly claimed that within the framework of the British National Health Service there has been developed a really good and complete service. . . ."

Advantages of the National Health Service

By SIR GUY DAIN

Member of the Central Advisory Council for the Ministry of Health, 1945-1950

IN THE world today governments of all political outlooks and all countries are implementing, each in its own way, and in enormously varying degrees, an implicit tenet of Christianity: the duty to feed the hungry and to care for the sick.

This found expression in Britain in 1948 in its National Health Service. In other articles in this issue the Service is described and the conditions existing before its establishment have been set out. The status of the British doctor under the National Health Service is evaluated.

My task in this article is to put forward the arguments in favour of the service. The chief, or most valuable, argument in favour of any service is the way in which it is and has been, of advantage to the people concerned. I propose to look at the service as it has affected the various people and bodies concerned. It was established by a Socialist Government determined to offer a medical service, free to the patient—whether in hospital or in his own home.

ADVANTAGES TO THE PATIENT

The first consideration (true in all medical problems) is the welfare of the patient. The advent of a service, free to everyone who might require it, provided advantages to the public which it is impossible to overestimate from the individual's point of view. Now he is free to choose his own doctor, free to

change doctors if he wishes (by giving the appropriate notice) free to see his doctor to resolve his fears or treat his pains, as the need arises. No question of cost comes between patient and doctor, and this provides the conditions for a perfect doctor-patient relationship. The practitioner can refer a patient to hospital for consultation, investigation, a second opinion, or for admission for treatment, all without hesitation on account of cost.

When setting out the advantages of this service today the problem of the cost of medical care, as compared with costs 20 or 30 years ago, should not be overlooked. Enormous advances in medical research and scientific progress have led to more accurate diagnosis and more effective treatment. Equally rapid advances in the products of pharmacy have added to the efficiency of medical care—but all at a cost.

It would not be an exaggeration to say that the cost of medical care today has put it out of the reach of many average unassisted citizens. It would be difficult to devise a system of health service that could be more advantageous from the patient's point of view than the National Health Service. That this has been properly appreciated is witnessed by the very large proportion of the population who have signed on with their doctors and make full use of the service. For people who do not wish to take advantage of the service, doctors (both those in the service

and those who are not) are available to all those who, for reasons of their own, wish to be treated as private patients and can afford private care. Both consultants and general practitioners in the service are usually available for private cases as well.

ADVANTAGES TO THE STATE

All this service has to be paid for; and another article in this issue explains how the government finds the money. It can properly be asked what the State is getting in return.

There is no doubt that the general health of the worker reduces the amount of absence from work due to illness, increases productive power and generally benefits the nation. The early access of patient to doctor is often also very time-saving. In addition, the government has the satisfaction of knowing that the service includes practically all the medical and surgical skills of the country and ensures provision of a first-rate service for everyone.

ADVANTAGES TO THE DOCTORS

The proposal to provide medical care in so wholesale and complete a system naturally gave rise to great anxiety among doctors regardless of their form of practice. The patient no longer needed to find a fee for any medical service he might require, because the government took on the obligation to pay the bills. This gave rise to many problems. When the cost of a service is paid by a third party who is not present when the service is given, complications immediately arise. Was the service properly given? Was the service necessary? How is the payer (in this case the government) to be sure that the service has been indeed performed?

The present National Health Service was established only after very long and thoughtful discussions between the government and the medical profession. To show the advantages to the medical profession it is necessary to make some comparison with previous conditions.

HOSPITAL SERVICE

Prior to 1948 hospitals were administered in two ways. Hospitals were either voluntary

in which case the consultant staff gave their services and were honorary officers, or hospitals were owned and administered by local authorities, where the consultant staff were whole time servants of the authority, on a salary. Consultants' incomes were derived from private practice in pay-beds or in nursing homes.

In the new service, all the hospitals were taken over by the state and the first idea was that the staffs would all be full-time officers. Ultimately it was decided that consultants appointed to a hospital should be free to take part-time service and be paid according to the number of sessions per week that were undertaken. The advantages to the consultant staff are that they are paid for all their hospital work. They are free to accept more or fewer sessions and to take private consultations and operations outside the service. They receive a pension on retirement at 65 years of age.

GENERAL MEDICAL PRACTICE

Prior to 1948, general practice was usually of two sorts. Ordinary private practice called for a fee for service paid by the patient. In addition, most practitioners treated patients covered by the Health Insurance Scheme which included all workers below an income limit and amounted to nearly half the population.

The first proposals from the government for the National Health Service for the general practitioner were that he should accept full-time salaried service and become, in effect, a civil servant. He would have been appointed to an area and neither he nor the patient would have had any choice in the matter. This proposed arrangement was dis-

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Sir Guy Dain entered general medical practice in 1897. He was a member of the council of the British Medical Association from 1921 to 1960, and chairman of the council from 1942 to 1948. He is a fellow of the Royal College of Surgeons, and was knighted in 1961.

Raising the questions "to what extent the individual can voluntarily exercise control over the provision of his medical services and the extent to which he is receiving the best possible medical services," this critic finds the British National Health Service inadequate.

Weaknesses of the National Health Service

By JOHN RECKLESS

Associate and Research Fellow in Psychiatry, Duke University Medical Center

Britain's National Health Service is popular with the patient, as public opinion polls show. To attempt to alter the present system would result in a political explosion. This is my first major criticism of a National Health Service (N.H.S.) which is now so entrenched in the political arena that needed reforms cannot take place.

I particularly wish to discuss here the fact that the hospital system for the provision of in-patient care is unsatisfactory. Because of financial difficulties hospitals cannot attract sufficient staff and cannot meet the immediate needs of the non-urgent patient at the time an illness is diagnosed.

The preventative aspects of medicine which were considered so necessary by the founders of the N.H.S. have not proved adequate, as I will attempt to show by discussing the dental and maternity services.

The needs of the aged and the young chronic sick—both specialized groups of patients expanding rapidly in number due to the increasing longevity of the population and the improved treatment skills of the physician—are not at present adequately met. Before the N.H.S. was introduced, it was thought that these very groups would be helped; these individuals could not provide requisites for themselves but the state with its power could provide them much more satisfactorily.

Research, the life blood of medicine, has been hampered by lack of funds. Progress has been slowed because of this. The total budget of the Medical Research Council was only \$12.8 million in 1962, while the total cost of the health service approached \$2.5 billion. For mental health \$280 million was spent on treatment but only \$691,000 on research investigation which would seek out the cause of illness and improve treatment methods. This despite the wealth of talent in the medical sciences in Great Britain.

Too many doctors have found the system unattractive and have emigrated. Virtually all countries in the Western Hemisphere face a doctor shortage, but Britain is one country that trains enough doctors but loses them after graduation.

The framework created by the N.H.S. has not encouraged the patient to seek out alternative private care. This has happened not by restriction of the privilege, but by draining the purse of the patient by high taxation, compulsory contributions to the N.H.S. social security tax, too few private beds in the government hospitals at too high a charge. Finally, a private patient is required to pay for the cost of drugs even though he has already been compelled to pay for them through taxation. This latter point is probably one of the major reasons why less than five per cent of Britain's medical practice is performed privately.

I support the principle of a subsidy for the patient who is in genuine financial need, with private practice provided for the patient able and willing to pay for more personalized and available service. I also strongly support the principle of voluntary prepayment health insurance. In this paper, to avoid repetition of companion articles, I will not present all the evidence at my disposal, but will concentrate on the more pertinent facts as outlined above. I will not dwell on the discontents of the medical profession and paramedical professions since this would be an essay in itself. The fact that the staffing situation in the service is so critical I think is evidence enough.

THE POLITICAL FRAMEWORK

The administrative framework in which the doctor and the patient relate is too politically sensitive. A primary weakness is financial. Other deficiencies irritating to doctor and patient alike spring from this major weakness. Since the system was "sold" to the patient by the politician as being "free," it is political folly to transfer more of the cost of the service from the central government treasury to the patient using the facilities of the N.H.S. However, since 1948, to avoid hardship and to maintain some standard of service for the ill additional charges for drugs, dental care, ophthalmic services and prosthetic devices have had to be introduced and periodically increased. Now with a recession looming in Great Britain, the government would like to spur the economy by reducing taxation. The main income for the N.H.S. is raised by taxation, so that a cut back in general taxation could lead to stagnation in the social services which would further foment political unrest.

A further point is that the N.H.S. framework lacks the flexibility to meet the medical

needs of an affluent society. Who could be in a better position to assess the service than the present Minister of Health, Mr. Enoch Powell?

In his first major speech after assuming office in the fall of 1960,¹ he stressed that the N.H.S., "by its very nature as a comprehensive state service holds out dangers and possibilities of harm as well as opportunities and possibilities for good." He noted that the great danger is rigidity. "The great machine is bound to have a one track mind, to be cumbrous and unresponsive, to abhor variations, to be insensitive to the world around it." He continued: "The N.H.S. Acts did, in fact, provide a framework which left room for adaptability and flexibility. But in the 13 years that have passed the grip of the great machine has tightened rather than loosened and Leviathan (The N.H.S.) has swollen to unhealthy proportion."

In a subsequent address, the Minister of Health declared that although he provided the framework in which doctors practiced their profession, it was not possible, in his informed opinion, to erect and maintain a framework in which medicine could be provided without making some value judgments on the practice of medicine itself.²

This frank statement provides the rationale for the physician to enter the political arena to defend both his livelihood and protect or be critical of the framework in which patient care is dispensed. Let me remind the reader that we are considering to what extent the individual can voluntarily exercise control over the provision of his medical services and the extent to which he is receiving the best possible medical services.

THE HOSPITAL SERVICE

Britain completed the building of no new hospitals in the first ten years of the health service, even though two out of three hospitals were built on their present sites over 70 years before.³ The Ministry of Health came into possession of a large number of hospitals, many of which were worn out and would have been even worse except for the Trojan work of some local authorities, who between

¹ Powell, Enoch, J., First major speech after assuming office, 1960.

² Powell, Enoch J., "The Elephant and the Whale," an address delivered on May 24, 1961, before the Winchester Division of the British Medical Association.

³ "Hospital Difficulties Today," *British Medical Journal*, Sept., 10: 1960, p. 788.

1930 and 1938 lavished large sums to improve their own hospitals.⁴ Financial supply during the first 12 years of the N.H.S. has been miserly. D. S. Lees estimates that before World War II, expenditure for capital purposes was about one-fifth as large as current health expenditure; since the war it has been equivalent to only three or four per cent.⁵

These figures indicate that following the acceptance by the government of responsibility for the nation's health care, there was a decrease in capital expenditure in the health service.

In February, 1962, the Ministry of Health announced a new 10-year hospital building plan.⁶ Under this plan, by 1971, some 750 hospitals will be off the scene or translated into something different. After 1971, a further 500 hospitals will suffer the same fate. This means that the Minister considers some 1250 hospitals of Britain's 3000 hospitals will have to be demolished. Large as is the sum to be expended on new hospital construction, it is only two-thirds of the amount that was recommended by the British Medical Association.

To succeed, the plan must find the money. Private funds, except for independent hospitals, have dried up and the country is dependent for the majority of its income on taxation.

Five months after the plan was announced, the government gave warning in the House of Commons that the 10-year plan for hospital building would depend on the economic and financial stability of the country. At this writing, Britain is experiencing a large

unemployment problem, and the economy is pointing downhill.

The government's financial priorities may vary from defense to education, and leave medicine as the Cinderella of the social services. Because of the high rate of taxation, fewer individuals can contribute privately or have the inclination to do so. Because of centralized control and direction, local communities cannot take steps on their own initiative to meet local demands for medical and hospital services, except through the medium of the centrally dominated N.H.S.

The lack of hospital expansion, coupled with over-utilization of hospital beds, has led to large waiting lists for hospital admission. The figure ever since 1948 has never been less than 450,000, has been as high as half a million, and currently stands at 466,000 patients awaiting elective hospital admission. While a bed can always be found for a serious medical or surgical emergency, a vast amount of relievable disability goes untended. In conditions such as hernia, varicose veins, hemorrhoids, and the uterine complaints of women, after the diagnosis has been made and treatment recommended, the patient may have to wait for periods between 6 weeks and 2 years before a hospital bed becomes available. While such waiting does not necessarily lead to an increased loss of life, the suffering, hardship and distress of the patient and the family can be imagined.

SHORTAGE OF HOSPITAL STAFF

This situation has become critical. There exists a shortage of junior hospital staff, and one-third of the present junior hospital physicians are from abroad, the majority coming from Commonwealth countries to spend only a short time in England. If substantial numbers of these junior physicians return home unexpectedly, there can be a breakdown of staffing at the resident staff level.

The number of specialists is also inadequate, and it is said that the specialists' responsibilities are being excessively or inappropriately delegated to senior hospital medical officers, residents and intern staffs.⁷ It has been noted that while such a practice

⁴ "British Hospitals as they were before 1948," Sir Allen Daley, M.D., LL.D., F.R.C.P., *British Medical Journal*, Sept. 10, 1960, pp. 758-763.

⁵ "The Economics of Health Services," D. S. Lees, Lecturer in Economics in the University College of North Staffordshire; an article presented at the "Association of Chief Financial Offices in the Health Service in England and Wales," November, 1959, *Lloyds Bank Review*, April, 1960.

⁶ "A Hospital Plan for England and Wales," Cmnd. 1604, H.M.S.O., London.

⁷ Medical Staffing in the Hospital Service: Report of a Joint Working Committee appointed in July, 1958, by the Minister of Health and Secretary of State for Scotland in collaboration with the Joint Consultant Committee, Supplement to the *British Medical Journal* for March 25, 1961.

gives practical experience to the training physician, this fact may provide cold comfort to the seriously ill patient. Since intending family doctors who form the bulk of the profession are denied hospital staff privileges when in practice, few elect to work in the hospital system and so the critical resident staff shortage continues.

An unknown number of British doctors are also leaving the United Kingdom as emigrants to other countries. The Minister has persistently denied any figure, but was stung to denial when an enterprising physician, Dr. John Seale, wrote to all physician licensing boards in the Commonwealth and other countries and ascertained that between 1956 and 1960, a total of 3530 British physicians emigrated from the United Kingdom. This is equivalent to one-third of all physicians who graduated from all British medical schools in that period. If this figure is true it may be concluded, states Dr. Seale, that the younger generation of the British medical profession is already severely depleted.⁸ This comes at a time when the proportion of learners, many from abroad, is growing in the health service and the number of doctors reaching retiring age is also expanding steadily. This may lead to a shortage of senior British doctors in the future and will probably affect adversely the quality of the service that the patient has been led to expect.

This physician emigration is of great interest, for one cannot run a health service successfully without staff. Evidences presented by the British Medical Association to the Pilkington Committee in 1958 showed that of 400 to 500 known general practitioners who had emigrated, a majority were of middle age, with remunerative practices and a stake in the country.⁹ The men now leaving graduated since the N.H.S. began, and never really knew private practice, yet still prefer to practice in a more attractive pro-

fessional climate. This depletion of Britains' physicians by emigration has been likened to a strike by individuals. But it is more serious than an industrial strike, for here the withdrawal of services by the physician is permanent and there is little prospect of replacement by British graduates. To understand one reason for the emigration of physicians we might again refer to the Minister's Winchester address. He stated:

The N.H.S. replaced a system which largely consisted of private practice . . . and which operated to keep the supply of doctors equal to the demand and to enable the ablest and most successful of them to earn if so inclined the biggest money. The N.H.S. has very largely and quite deliberately destroyed this market, which has had to be replaced by an artificial mechanism, not only for determining the amount as well as the system of remuneration, but also for regulating the supply of trainees for the profession and securing some financial reward for distinction.¹⁰

Remuneration has been a continuing source of friction between the physician and the government, together with the fact that the Minister has the authority not only to decide who shall practice but where he shall practice. It is not surprising that individualists have decided that this amount of government regulation is too much to stomach.

Similar shortages and salary frictions exist in nursing, X-ray technology and physiotherapy, and services to the patient have had to be curtailed in these areas.

THE PREVENTIVE MEDICAL SERVICES

The N.H.S. act was designed to promote the good health of the people as well as to treat ill health. I would like to focus on two groups of people—the children and their dental care and the prenatal care of the pregnant woman.

Dental care is part of the service, and dentists, unlike doctors, are paid a fee per service though it is inadequate. Dentists are able to exercise control over their income by the amount of surgery undertaken. For this reason, salaried dentists in the school dental service resigned to join the N.H.S., even though their employer was still the government.

⁸ Seale, J., Medical Emigration from Britain, 1930-1961, *British Medical Journal*, March 17, 1962.

⁹ Medical Staffing Structure in the Hospital Service, Report of the Joint Working Party, 1961, H.M.S.O., London.

¹⁰ *Op. cit.*, Powell, Enoch J.

The effect of this can be judged by the statement in December, 1962, by the chairman of the Council of the British Dental Association. The Chairman disclosed that the whole picture of dental health of school children is a national scandal, but that the Association could not get anyone to appreciate just how serious it was. He noted that there are 17 million school children and his Association would like to see each child examined at least 3 times a year. He stated that only half the children were examined once a year, and only half received treatment.

Inspection of the school dental service of 146 local education authorities in England and Wales is carried out by one dental officer and he has no staff. More than double the present number of dentists are needed. The productivity of the dentists and the school dental services has fallen steadily, from 1100 patients per dentist in 1952 to 700 patients per dentist in 1961. This fall-off offers a startling contrast to the rise in productivity among dentists practicing in the N.H.S. dental service over the same period of time.

PATIENT PAYS TWICE

To conclude this section on an ironic note: Britain's dentists, working harder to meet the demands of treatment, and with the aid of new high-speed equipment, earned higher incomes as a result. Imagine their surprise when they were told, in the summer of 1962, that their fees would be arbitrarily reduced. The British Dental Association commented that in no other walk of life would the reward for a reorganized and efficient service be a reduction in fees. Now, in 1963, it is reported that private practice is returning in force because there are now too few dentists, with too much work, who are paid too little by the N.H.S. Nearly 2000 dentists are refusing to fit dentures under the N.H.S. because of the fee.* This is a withdrawal mechanism similar to that of the doctors ex-

cept that it is not by emigration. Who pays? The patient, but he pays twice because he receives no credit for his N.H.S. contribution, and he has no opportunity to withdraw from contributing to the N.H.S.

MATERNITY CARE

Having a baby is a normal function, which lends itself to good preventive medical care. No mother pays for her treatment at the time she receives it, and hospital beds for those who eventually reach them are free. I would like to report on a survey carried out on the standards of maternity care.¹¹ The survey studied all births in the United Kingdom in one week in 1958, and for a previous three-month period carried out a study of all infant deaths prior to delivery.

Although 98 per cent of mothers received some ante-natal care, 49 per cent (the majority of them intending to have a home delivery) did not receive the full amount of care required because they did not report for examination until after the 16th week of pregnancy. Three-fifths of the wives of the professional classes began their ante-natal care early (before the 16th week) but only two-fifths of the wives of unskilled workers did so. The death rate of babies of the professional class was half that in the class of unskilled labor and late attendance may have contributed to these results.

There was a need for ante-natal beds shown by this survey. More than 1 in 4 of all the mothers in the survey had raised blood pressure and these were responsible for more than half the dead babies. Once serious blood pressure problems developed in the mother the baby was three times more likely to die, yet less than half the mothers who suffered severe high blood pressure were admitted to hospital for necessary treatment.

Owing to a shortage of maternity beds in hospitals having a resident medical staff, and under the direction of an obstetric specialist, only 49 per cent of all mothers in the survey (including emergency cases who were originally booked for admission elsewhere) were delivered in hospital. Thirty-six per cent were delivered at home, 12 per

* Exceptions to this are made in the case of aged and indigent patients.

¹¹ Perinatal Mortality Survey, Performed under the auspices of the National Birthday Trust Fund, October, 1962.

cent in maternity homes without a resident doctor, blood bank or equipment for certain operative procedures; 3 per cent made private arrangements outside the N.H.S. or were delivered in various transports on the way to hospital.

On the basis of the recommendations of a Committee to study the maternity services it was suggested that for appropriate treatment all women having their first or fifth or subsequent pregnancy as well as those having abnormalities outside these categories should be delivered in a hospital. The shortage of beds clearly made this impossible in some areas but a better selection of cases for the limited number available could have achieved an improvement. One-third of all mothers of first babies were not booked for confinement in the hospital, nor were 70 per cent of patients having their 5th or subsequent babies (carrying a 60 per cent increased risk to the baby). One in four of all first babies booked for home delivery had to be transferred to hospital care late in pregnancy or during labor.

The challenge revealed by this survey is that each year an estimated 25,000 babies in Britain are born dead or die within the first week of life. Although Britain's health services are facing the need for better facilities and hospitals to improve the standard of medical care, there is little room for complacency in the maternity services. The patient may now have the right to treatment but until more money is found correction for the situation will be slow.

NEED FOR PRIVATE PRACTICE

If only private practice could be encouraged and independent hospitals built, this would relieve the situation greatly. If a tax credit could be given to the private patient and drugs could be provided under the same terms as for the N.H.S. patient a great stride forward could be made.

Private voluntary pre-payment health in-

surance in Great Britain has increased from 100 thousand people covered in 1951, to over one million people today. The Nuffield Trust, a private charitable foundation, has aided in the building of seven new small private hospitals. It made grants conditional on local communities providing additional funds through private giving. The response was fast and immediate.¹²

How much faster progress could be made if the government encouraged private practice, and independent hospitals! Local communities will give to provide hospitals under local control, especially one that meets a need not met by the N.H.S. hospitals.

NEEDS OF THE AGED

It is interesting to compare how these patient groups have fared under a system of compulsory government medical care. In November, 1960, the British Medical Association was asked to participate in supplying its opinion to a government sponsored investigation by the medical services review committee (the Porritt Committee).¹³ On January 28, 1961, the Association's Findings were published and the responses were based on the survey within the framework of the membership of the British Medical Association.

When asked if present facilities for the care of the chronic sick and elderly patient were adequate, the answer was no, and the replies indicated that there should be more hospital beds, day hostels, and short stay convalescent facilities.

My own view is that with the diminished capital investment in the N.H.S., little real effort has been made to build, equip and staff special treatment centers for the chronic sick and elderly patients. The chronic sick do not need the acute treatment facilities of a general hospital but rather need remedial services and after-care facilities. Convalescent facilities are required for the chronic sick and geriatric patient with specially designed buildings to avoid increasing the psychological problems imposed by their reduced mobility and loneliness. To house these patients in an acute hospital is wasteful, both in terms of bed space and cost, for

¹² The Nuffield Nursing Homes Trust, *British Medical Journal*, July 21, 1962.

¹³ Porritt Committee's Questionnaire, British Medical Association's Answers. Supplement, *British Medical Journal*, Jan. 28, 1961, p. 24-29.

it costs much more to stay in an acute general hospital than in a convalescent home, and general hospital beds are needed for the acutely ill.

HOSPITALIZATION OF THE AGED

Many people believe that the financial workings of the welfare state tend to dissuade the family from the choice of home treatment and to encourage the population to be treated in hospitals. A good example of this is the financial provision in relation to the aged sick in Great Britain. Even following admission to hospital, the old-age pension can be drawn for the patient by a relative. It is believed that many families continue to draw the pension while the patient is in the hospital and, of course, the family is relieved of the necessity to provide food and laundry for the patient.

It becomes evident that there is every financial inducement to send an aged relative into the hospital and once he is there to keep him there. When so many families particularly in the lower income groups are in debt to credit agencies, the temptation placed gratuitously within their reach by the state can readily be appreciated.

Critics point out that the doctors are responsible for the length of time that the patient stays in the hospital. This is an oversimplification. If relatives are not available or are unwilling to take care of an elderly patient (who is over the acute phase of his illness, but who still requires some convalescent facilities), the physician faces an impasse.

The doctor has no option but to allow the patient to remain in the acute hospital bed. Arbitrarily to discharge the patient would expose the physician to much political and legal criticism and place him in the center of an unpleasant controversy. When such a situation is multiplied, it is easy to see how the hospital bed turnover is reduced and the availability of hospital beds rapidly diminishes.

¹⁴ Jewkes, J. and S., *"The Genesis of the National Health Service,"* published by Basil Blackwell, Oxford, 1961.

CONCLUSION

My term of reference requested by the editor in writing this paper was to point out what I considered to be the arguments against the N.H.S. My attitude to the service is not so negative as this paper would suggest. N.H.S. has many advantages for the British patient and the profession. It met in one way the particular needs of that country in 1948. The present Minister of Health, Mr. Enoch Powell, has adopted a refreshingly vigorous attack on the inadequacies of the system.

Were it at all possible to get medicine away from the political arena, to dilute the monolithic monopolistic structure of the N.H.S. and to transfer some of the burdens of financing the service back to the patient using the facilities, much could be done to improve the position of patient and doctor alike. There is a demand for private practice and it should and must return. Prepayment voluntary health insurance would seem to be a logical way to lighten the burden on the individual.

A parting thought: where a uniform compulsory social security payroll withholding tax (such as the N.H.S.) is taken from rich and poor alike many people interpret this to mean that the rich help the poor sick. It also means, as Professor Jewkes has pointed out, that the healthy poor subsidize the medical costs of the more frequently ill rich.¹⁴

John Reckless is an Englishman who received his medical education at the University of Birmingham, in England. He practiced under the National Health Service and in the British Royal Medical Corporation for a period of three years. In 1958, he came to America where he has since completed his residency training in psychiatry, and is now in practice and on the faculty at the Duke University Medical Center, Durham, North Carolina. In the fall of 1961, he returned to England for further training and spent three months studying the British hospital system.

CURRENT DOCUMENTS

The Hospital Insurance Bill of 1963

In February, 1963, a bill providing payment for medical care for the aged under the social security program was introduced in the House of Representatives by Cecil King of California (H.R.3920) and in the Senate by Clinton P. Anderson of New Mexico (S.880). The Bill's Findings and Declaration of Purpose, and sections 1701 through 1705 and section 1709 (a) and (b) are reprinted here in full.¹

FINDINGS AND DECLARATION OF PURPOSE

SEC. 2. (a) The Congress hereby finds that (1) the heavy costs of hospital care and related health care are a grave threat to the security of aged individuals, (2) most of them are not able to qualify for and to afford private insurance adequately protecting them against such costs, (3) many of them are accordingly forced to apply for private or public aid, accentuating the financial difficulties of hospitals and private or public welfare agencies and the burdens on the general revenues, and (4) it is in the interest of the general welfare for financial burdens resulting from hospital services and related services required by these individuals to be met primarily through social insurance.

(b) The purposes of this Act are (1) to provide aged individuals entitled to benefits under the old-age, survivors, and disability insurance system or the railroad retirement system with basic protection against the costs of inpatient hospital services, and to provide, in addition, as an alternative to inpatient hospital care, protection against the costs of certain skilled nursing facility services, home health services, and outpatient hospital diagnostic services; to utilize social insurance for financing the protection so provided; to encourage, and make it possible for, such individuals to purchase protection against other

health costs by providing in such basic social insurance protection a set of benefits which can easily be supplemented by a State, private insurance, or other methods; to assure adequate and prompt payment on behalf of these individuals to the providers of these services; and to do these things in a manner consistent with the dignity and self-respect of each individual, without interfering in any way with the free choice of physicians or other health personnel or facilities by the individual, and without the exercise of any Federal supervision or control over the practice of medicine by any doctor or over the manner in which medical services are provided by any hospital; and (2) to provide such basic protection, financed from general revenues, to those persons who are now age 65 or over or who will reach age 65 within the next several years and who are not eligible for benefits under the old-age, survivors, and disability insurance or railroad retirement systems.

(c) It is hereby declared to be the policy of the Congress that skilled nursing facility services for which payment may be made under this Act shall be utilized in lieu of inpatient hospital services where skilled nursing facility services would suffice in meeting the medical needs of the patient, and that home health services for which payment may be made under this Act shall be utilized in lieu of inpatient hospital or skilled nursing facility services where home health services would suffice.

¹ Sections (c) through (g) of Section 1709 will follow in our August issue.

(d) It is further declared to be the policy of the Congress that no individual who receives aid or assistance (including medical or any other type of remedial care) under a State plan approved under title I, IV, X, XIV, or XVI of the Social Security Act shall receive less benefits or be otherwise disadvantaged by reason of the enactment of this Act.

TITLE I—HOSPITAL INSURANCE BENEFITS FOR THE AGED BENEFITS

SEC. 101. The Social Security Act is amended by adding after title XVI the following new title:

"TITLE XVII—HOSPITAL INSURANCE BENEFITS FOR THE AGED

"PROHIBITION AGAINST ANY FEDERAL INTERFERENCE

"SEC. 1701. Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any hospital, skilled nursing facility, or home health agency; or to exercise any supervision or control over the administration or operation of any such hospital, facility, or agency.

"FREE CHOICE BY PATIENT GUARANTEED

"SEC. 1702. Any individual entitled to have payment made under this title for services furnished him may obtain inpatient hospital services, skilled nursing facility services, home health services, or outpatient hospital diagnostic services from any provider of services with which an agreement is in effect under this title and which undertakes to provide him such services.

"DESCRIPTION OF SERVICES

"SEC. 1703. For purposes of this title—
"Inpatient Hospital Services

"(a) The term 'inpatient hospital services' means the following items and services furnished to an inpatient in a hospital and (except as provided in paragraph (3)) by the hospital—

"(1) bed and board,

"(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are customarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are customarily furnished by such hospital for the care and treatment of inpatients, and

"(3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are customarily furnished to inpatients either by such hospital or by others under such arrangements; excluding, however—

"(4) medical or surgical services provided by a physician, resident, or intern, except services provided in the field of pathology, radiology, physiatry, or anesthesiology, and except services provided in the hospital by an intern or a resident-in-training under a teaching program approved by the Council on Medical Education and Hospitals of the American Medical Association (or, in the case of an osteopathic hospital, approved by a recognized body approved for the purpose by the Secretary), and

"(5) the services of a private-duty nurse.

"Skilled Nursing Facility Services

"(b) The term 'skilled nursing facility services' means the following items and services furnished to an inpatient in a skilled nursing facility, after transfer from a hospital in which he was an inpatient, and (except as provided in paragraph (3)) by such skilled nursing facility—

"(1) nursing care provided by or under the supervision of a registered professional nurse,

"(2) bed and board in connection with the furnishing of such nursing care,

"(3) physical, occupational, or speech

therapy furnished by the skilled nursing facility or by others under arrangements with them made by the facility,

“(4) medical social services,

“(5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility, as are customarily furnished by such facility for the care and treatment of inpatients,

“(6) medical services provided by an intern or resident-in-training of the hospital, with which the facility is affiliated or under common control, under a teaching program of such hospital approved as provided in subsection (a) (4), and

“(7) such other services necessary to the health of the patient as are generally provided by skilled nursing facilities;

excluding, however, any item or service if it would not be included under subsection (a) if furnished to an inpatient in a hospital.

“Home Health Services

“(c) The term ‘home health services’ means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are provided in a place of residence used as such individual’s home—

“(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse,

“(2) physical, occupational, or speech therapy,

“(3) medical social services,

“(4) to the extent permitted in regulations, part-time or intermittent services of a home health aid,

“(5) medical supplies (other than drugs and biologicals), and the use of medical appliances, while under such a plan, and

“(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hos-

pital, under a teaching program of such hospital approved as provided in subsection (a) (4);

excluding however, any item or service if it would not be included under subsection (a) if furnished to an inpatient in a hospital.

“Outpatient Hospital Diagnostic Services

“(d) The term ‘outpatient hospital diagnostic services’ means diagnostic services—

“(1) which are furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and

“(2) which are customarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

excluding, however—

“(3) any item or service if it would not be included under subsection (a) if furnished to an inpatient in a hospital; and

“(4) any service furnished under such arrangements unless (A) furnished in the hospital or in other facilities operated by or under the supervision of the hospital, and (B) in the case of professional services, furnished by or under the responsibility of members of the hospital medical staff acting as such members.

“Drugs and Biologicals

“(e) The term ‘drugs’ and the term ‘biologicals’, except for purposes of subsection (c) (5) of this section, include only such drugs and biologicals, respectively, as are included in the United States Pharmacopoeia, National Formulary, New and Non-Official Drugs, or Accepted Dental Remedies, or are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs or biologicals (or of the hospital with which the skilled nursing facility furnishing such drugs or biologicals is affiliated or is under common control).

“Arrangements for Certain Services

“(f) As used in this section, the term ‘arrangements’ is limited to arrangements under

which receipt of payment by the hospital, skilled nursing facility, or home health agency (whether in its own right or as agent), as the case may be, with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

"DEDUCTIBLE; DURATION OF SERVICES

"Deductible

"SEC. 1704. (a) (1) Except as provided in subsection (c), payment for inpatient hospital services furnished an individual during any benefit period shall be reduced by a deduction equal to \$20, or if greater, \$10 multiplied by the number of days, not exceeding nine, for which he received such services in such period.

"(2) Payment for outpatient hospital diagnostic services furnished an individual during any thirty-day period shall be reduced by a deduction equal to \$20. For purposes of the preceding sentence, a thirty-day period for any individual is a period of thirty consecutive days beginning with the first day (not included in a previous such period) on which he is entitled to benefits under this title and on which outpatient hospital diagnostic services are furnished him.

"Duration of Services

"(b) Payment under this title for services furnished any individual during a benefit period may not be made for—

"(1) inpatient hospital services furnished to him during such period after such services have been furnished to him for 90 days during such period, except as provided in subsection (c); or

"(2) skilled nursing facility services furnished to him during such period after such services have been furnished to him for 180 days during such period.

For purposes of the preceding provisions of this subsection, inpatient hospital services or skilled nursing facility services shall be counted only if payment is or would, except for this subsection and except for the failure

to comply with the procedural and other requirements of or under section 1709 (a) (1), be made with respect to such services under this title. Payment under this title for home health services furnished an individual during a calendar year may not be made for any such services after such services have been furnished him during 240 visits in such year.

"Election as to Duration of Inpatient Hospital Services and Deductible

"(c) (1) An individual may elect, instead of the number of days in a benefit period for which payment may be made for inpatient hospital services furnished to him specified in subsection (b) (1)—

"(A) to have such number of days for each benefit period increased to 180, and, in such case, the payment under this title for inpatient hospital services furnished him during any benefit period shall, instead of being reduced by the deduction specified in subsection (a) (1), be reduced by a deduction equal to either (i) $2\frac{1}{2}$ times the average per diem rate for such services, determined under paragraph (4), or (ii) if less, the charges customarily made for such services by the hospital which furnished them, or

"(B) to have such number of days reduced to 45 for each benefit period and, in such case, the reduction, provided in subsection (a) (1), in the payment under this title for inpatient hospital services furnished during any benefit period shall not apply to him.

"(2) An individual may make an election under paragraph (1) only on such form or forms and in such manner as the Secretary may prescribe. Any such election shall be valid only if made before the month preceding, and after the fourth month preceding, the first month in which he both has attained the age of 65 and is eligible for the benefits referred to in section 1705 (a) (2); except that if such first month occurs before January 1965, such election shall be valid only if made after May 1964 and before December 1964. For purposes of the preceding sentence, (A) an individual shall be regarded as eligible for benefits for a month

if he is or, upon filing application for such benefits in such month, would be entitled to such benefits, and (B) an individual to whom section 103 of the Hospital Insurance Act of 1963 applies shall be deemed eligible for the benefits referred to in such section 1705 (a) (2) for and after the month in which he attains the age of 65.

“(3) An individual shall be permitted only one election under this subsection and such election shall be irrevocable.

“(4) The Secretary shall, between July 1 and October 1 of the calendar year 1966 and of each calendar year thereafter, promulgate the average per diem rate for inpatient hospital services which shall be applicable in the case of benefit periods beginning during the succeeding year. Such promulgation shall be based on the best information available to the Secretary (at the time the determination is made) as to the amounts paid under this title on account of inpatient hospital services furnished, during the calendar year preceding such determination, by hospitals, with which agreements under section 1710 are in effect, to individuals who are entitled to have such payments made with respect to such services; and the amount so determined shall be rounded to the nearest \$1, or, if it is a multiple of \$0.50 but not of \$1, to the next higher \$1. For benefit periods beginning prior to the calendar year 1967, such average per diem rate shall be \$37.

“Benefit Period

“(d) For the purposes of this section, a ‘benefit period’ with respect to any individual means a period of consecutive days—

“(1) beginning with the first day (not included in a previous benefit period) (A) on which such individual is furnished inpatient hospital services or skilled nursing facility services and (B) which occurs in a month for which he is entitled to insurance benefits under this title, and

“(2) ending with the ninetieth day thereafter on each of which he is neither an inpatient in a hospital nor an inpatient in a skilled nursing facility (whether or not such

90 days are consecutive), but only if such 90 days occur within a period of not more than 180 consecutive days.

“ENTITLEMENT TO BENEFITS

“SEC. 1705. (a) Every individual who—

“(1) has attained the age of 65, and

“(2) is entitled to monthly insurance benefits under section 202,

shall be entitled to insurance benefits under this title for each month for which he is entitled to such benefits under section 202, beginning with the first month after December 1964 with respect to which he meets the conditions specified in paragraphs (1) and (2).

“(b) For the purposes of this section—

“(1) entitlement of an individual to insurance benefits under this title for a month shall consist of entitlement to have payment made under, and subject to the limitations in, this title on his behalf for inpatient hospital services, skilled nursing facility services, home health services, and outpatient hospital diagnostic services furnished him in the United States during such month; and

“(2) an individual shall be deemed entitled to monthly insurance benefits under section 202 for the month in which he died if he would have been entitled to such benefits for such month had he died in the next month.

“(c) Notwithstanding the preceding provisions of this section, no payments may be made under this title for inpatient hospital services, outpatient hospital diagnostic services, or home health services furnished an individual prior to January 1, 1965, or for skilled nursing facility services furnished him prior to July 1, 1965.

[Section 1706 defines the “providers of services”; section 1707 deals with the “use of state agencies and other organizations to develop conditions of participation for providers of services”; section 1708 deals with the “use of state agencies and other organizations to determine compliance by providers of services with conditions of participation.”]

"CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

"Requirement of Requests and Certifications

"SEC. 1709. (a) Except as provided in subsection (f), payment for services furnished an individual may be made only to eligible providers of services and only if—

"(1) written request, signed by such individual except in cases in which the Secretary finds it impractical for the individual to do so, is filed for such payment in such form, in such manner, within such time, and by such person or persons as the Secretary may by regulation prescribe;

"(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases and with such frequency, appropriate to the case involved, as may be provided in regulations) that—

"(A) in the case of inpatient hospital services, such services are or were required for such individual's medical treatment, or such services are or were required for inpatient diagnostic study;

"(B) in the case of outpatient hospital diagnostic services, such services are or were required for diagnostic study;

"(C) in the case of skilled nursing facility services, such services are or were required because the individual needed skilled nursing care on a continuing basis for any of the conditions with respect to which he was receiving inpatient hospital services prior to transfer to the skilled nursing facility or for a condition requiring such care which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services;

"(D) in the case of home health services, such services are or were required because the individual needed skilled nursing care on an intermittent basis or because he needed physical or speech therapy; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician;

"(3) with respect to inpatient hospital services or skilled nursing facility services furnished such individual after the twenty-first day of a continuous period of such services, there was not in effect, at the time of admission of such individual to the hospital, a decision under section 1710 (e) (based on a finding that timely utilization review of long-stay cases is not being made in such hospital or facility);

"(4) with respect to inpatient hospital services or skilled nursing facility services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group) pursuant to the system of utilization review that further inpatient hospital services or further skilled nursing facility services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished in such period before the fourth day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding.

"Determination of Costs of Services

"(b) The amount paid to any provider of services with respect to services for which payment may be made under this title shall be the reasonable cost of such services, as determined in accordance with regulations establishing the method or methods to be used in determining such costs for various types or classes of institutions, services, and agencies. In prescribing such regulations, the Secretary shall consider, among other things, the principles generally applied by national organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for payment on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, and may provide for the use of estimates of costs of particular items or services.

BOOK REVIEWS

ON MEDICAL CARE

AMA: THE VOICE OF AMERICAN MEDICINE. BY JAMES G. BURROW. (Baltimore: Johns Hopkins Press, 1963. 396 pages, appendix and index, \$7.50.)

Tracing the rise of the American Medical Association from its first meeting of some 100 doctors in New York in 1846, James Burrow details "the enormous influence the American Medical Association has exercised over the development of national programs involving matters of health and medicine." In the nineteenth century, the A.M.A. was politically insignificant, faced with sectarian medical practitioners who followed various nonconventional healing cults, with sectional divisions and organizational weaknesses. In the twentieth century, the Association set up political machinery and agitated for federal food and drug legislation, for a federal health department, for exposure of medical quackery, and for higher standards of medical advertising. After World War I, the Association began to oppose plans for compulsory health insurance; since its first official pronouncement in 1920, it has not wavered in its opposition to such programs. This detailed study offers readers a great deal of information on the A.M.A.'s history and policies and the reasons for its attitudes toward health practices and governmental responsibilities in the twentieth century.

FUNDAMENTALS OF VOLUNTARY HEALTH CARE. EDITED BY GEORGE B. DE HUSZAR. (Caldwell, Idaho: The Caxton Printers, 1962. 457 pages, \$6.00.)

All the articles in this symposium favor some form of voluntary health care; in the words of the editor: "Voluntary associations and activities are the lifeblood of a

free society. . . ." Articles on "The Lengthening Shadow of Government," "Decline of Individualism," and "Our Enemy, the State" and others underline the moral, biological and economic framework of the issues involved, which make up Part I of the symposium. Part II deals with the "Basic Issues of Voluntary vs. Compulsory Health Care," including a section on the dangers of government intervention. This is a thought-provoking set of essays with a single premise.

FAMILY MEDICAL CARE. A REPORT ON THE FAMILY HEALTH MAINTENANCE DEMONSTRATION. BY GEORGE A. SILVER. (Cambridge: Harvard University Press, 1963. 243 pages, appendices, bibliography, notes and index, \$9.75.)

Between 1951 and 1958 the staff of Montefiore Hospital in New York city directed a Family Health Maintenance Demonstration under government sponsorship, to study the practicability of offering a type of comprehensive medical team care to a selected group of families. The assumptions of the project were "that something could be done (and observed) that would favorably influence the health of families concerned," that "advice and guidance in daily medical practice" would be helpful, and that "a health team, substituting for the family doctor, is an appropriate device for carrying on these daily health services."

From 5,000 families belonging to the Montefiore Medical Group of the Health Insurance Plan of Greater New York (the HIP plan), 35 families were selected as a pilot group for a 5-year study. A physician, nurse and social welfare made up the Family Health Maintenance team; they could call on consulting specialists. Dr. Silver has prepared a careful and detailed study

of the five-year project, an interesting experiment in medical team practice.

FINANCING MEDICAL CARE. An Appraisal of Foreign Programs. EDITED BY HELMUT SCHOECK. (Caldwell, Idaho: The Caxton Printers, 1962. 305 pages and indices, \$5.50.)

As F. A. Hayek points out in his preface to this symposium, "The creation of any kind of government-controlled compulsory organization of medical service is a step which may have the most far-reaching effects on the structure of a society and even on the character of a people." Chapters in this study deal with medical care in Britain, France, Germany, Austria, Sweden, Switzerland, and Australia. One generalization that Hayek makes about all these nations and their health experiments is "that the results of their adoption differ widely from, and generally fall greatly short of, the expectations which led to their adoption." The general viewpoint in this study is unfavorable to government-financed medical care. The articles make a contribution to our knowledge of the problems of government and private medicine.

T.H.B.

HISTORY AND POLITICS

IN SEARCH OF FRANCE. BY STANLEY HOFFMANN, CHARLES P. KINDLEBERGER, LAURENCE WYLIE, JESSE R. PITTS, JEAN-BAPTISTE DUROSELLE, FRANÇOIS GOGUEL. (Cambridge: Harvard University Press, 1963. 443 pages and index, \$8.95.)

As François Goguel puts it in the admirable concluding essay of this admirable book, here is the work of six authors in search of a national character. A country, a society, marked by continuity amounting almost to inertia gives sudden signs of dynamic progress; a once-great power, hard on the decline, reclaims a leading political and economic role. The phenomenon is recent, significant, and it affects

more than just the students of French affairs. This book provides some most distinguished and up-to-date explanations of what goes on in France, and why: Stanley Hoffmann discusses politics and the political mentality in a historical context; Charles P. Kindleberger, the resurgence of French economy; Laurence Wylie and Jesse R. Pitts, social change in rural and in urban settings; Jean-Baptiste Duroselle, foreign policy since 1945; François Goguel presents an analysis that goes much further than the "suspended judgment" on which it seems to end.

No brief account can reproduce the subtle and original discussions of a book which no student of the contemporary scene should miss. It is not easy reading. It is a close-packed, suggestive and important book.

EUGEN WEBER

University of California, Los Angeles

BERLIN AND THE FUTURE OF EAST-ERN EUROPE. Edited by David S. Collier and Kurt Glaser. (Chicago: Henry Regnery Company, 1963. 251 pages, and index, \$6.00.)

Understandably, the problem of Berlin is critical to the long-range prospects of peace in Europe; in Berlin, through miscalculation, a chain reaction could be triggered that would start a new war. More has been written about Berlin than perhaps any other single source of conflict between the Western Powers and the Soviet Union.

This collection of articles attempts to deal with various facets of the Berlin question. The serious student and specialist will find little new; but many of the essays provide useful summations of where we have come from, and where we are, though the generality of the prescriptions for future policy are to be regretted. There is also a preponderant emphasis upon military analyses which often seem to lose sight of the fact that contemporary military technology demands attention to new, imaginative, realizable political solutions in-

stead of reliance upon shopworn slogans and policies.

A.Z.R.

1918—THE LAST ACT. BY BARRIE PITT. (New York: W. W. Norton & Co., 1962. xii, 318 pages, photographs, maps, bibliography, and index, \$5.95.)

Barrie Pitt has written a readable account of the military history of the last year of World War I. The book centers around the last great Spring Offensive of General Ludendorff, the failure of which precipitated his "failure of nerve" and his demand from his nominal political superiors for an immediate armistice. The war revealed the inadequacy and the stupidity of the older generation of military leadership in all countries. Pitt is correct in criticizing the Germans least—at least on the level of the purely military. Politically, Ludendorff's underestimation of the strength of his armies late in 1918 proved a major political disaster for Imperial Germany.

HERMAN LEBOVICS
Brooklyn College

THE RED ARMY OF CHINA: A SHORT HISTORY. BY EDGAR O'BALLANCE. (New York: Frederick A. Praeger, Inc. 1963. 232 pages, appendix and index, \$6.00.)

This brief military history tells "of the painful birth of the Red Army, its desperate early struggles, and how the two great characters, Chu Teh and Mao Tse-tung, met in the mountain fastness of a traditional bandit lair to form a lasting friendship." The author relates, with clarity and interest, the story of Chiang Kai-shek's efforts to destroy the Chinese Communists, of the impact of the Japanese invasion of 1937 on this struggle, and of the postwar emergence of the Chinese Red Army.

A.Z.R.

THE SOVIET UNION AT THE UNITED NATIONS. BY ALEXANDER DALLIN. (New York: Frederick A. Praeger, 1962.

224 pages, \$5.75. Also available in paperback.)

Public attention in the United States has long been centered on Soviet policy and behavior in the United Nations. Each year, particularly when the General Assembly is in session, there is an outpouring of articles and opinions. But no one has hitherto attempted to present a systematic account of Moscow's objectives in, and attitudes toward, the U.N. and other international organizations. Professor Alexander Dallin of Columbia University has taken an important step toward filling this void in our knowledge.

Part one discusses the antecedents of the present Soviet attitude by touching on the influence of ideology on Soviet policy, the U.S.S.R.'s role in the League of Nations, and the record of Soviet participation in the U.N. during the Stalinist era. Part two offers a capsule analysis of Moscow's views on such critical issues as national sovereignty, the veto, proposals for revising the Charter, the role of the specialized agencies, disarmament, and the performance of Soviet officials at the U.N. Despite the brief treatment accorded these important topics, the analyses are authoritative and well-balanced.

The final part discusses in greater detail Premier Khrushchev's Challenge to the United Nations. Professor Dallin shows convincingly that the Kremlin is intent upon bending the United Nations to its own purposes, and that it has been able to make common cause with the growing neutralist membership on a number of issues opposing the West.

This is a hard-headed, sober, no-nonsense book which will undoubtedly upset many people who still entertain great expectations for the United Nations, but it is all the more important that it be read and discussed. For the facts are clear and accurately presented, and they add up to growing difficulties for the United Nations.

A.Z.R.

(Continued on page 52)

BEFORE WORLD WAR II

(Continued from page 5)

eligibility was reduced from 16 to 14. Additional state aid was granted and some of the weaker approved societies were merged.

An administrative change came about with the organization of the Ministry of Health in 1919. This newly-established Ministry took over the administration of the plan, a task which would have formerly been assigned to the Local Government Board. However, as in 1911, direct local control was carried on by the local committees.

Despite these changes, aimed at extending benefits and improving administration, there was general agreement even before the beginning of the Second World War when about 77 per cent of men and 39 per cent of the women between the ages of 14 and 64, or 40 per cent of the population as a whole, was covered, that the act of 1911 required not patching but replacement. The problems raised by World War II with respect to medical services accelerated the demand for improvements and for studies as to how to achieve further extension of the health services. The National Health Service Act, by extending coverage to about 95 per cent of the population, by including specialist and hospital services in the benefits, and by drastically revising and improving the administrative machinery, was a giant step forward in reaching the avowed goal of the Government: that adequate medical care should be provided for each individual without regard to his financial resources. In the words of the Coalition Government White Paper of 1944, the purpose was "to divorce the care of health from questions of personal means and other factors irrelevant."

This was a far cry from 1911. Yet for all its deficiencies, the 1911 Act was the foundation for the 1946 Act. The administration was radically revised and benefits and services were vastly extended, but the basic concept of panels of physicians who voluntarily joined the system and from which the patient

was free to choose his own doctor was retained. For better or for worse, the prospect of establishing truly "socialized medicine" in Great Britain had been rendered virtually impossible by the Health Insurance Act of 1911 which set the basis for the National Health Service Act of 1946.

GENESIS OF THE N.H.S.

(Continued from page 11)

eral hospital should provide (sometimes a single hospital does so and has its own committee); the Committees coordinate the combined hospitals to prevent undue duplication or gaps in service and to achieve a desirable concentration of special services in particular units. Specialists serve under contract to the hospital authorities and are paid salaries commensurate with their experience and skill (rather munificent salaries, one might add). They are also entitled to carry on private practice; indeed most Health Service hospitals themselves provide private beds for that purpose. Patients go to hospitals, as before, on the referral of doctors.

(c) The third party of the administrative structure involves various *miscellaneous services* provided by local government units. These local units lost their hospitals in the general reorganization but still have broad responsibilities for auxiliary and preventive services of various sorts.

This sketch, though brief, should at least illustrate some of the themes I have stressed: the extent to which objectives stemming from a concern with the efficiency and rational organization of medical services supplement, indeed overshadow, mere "medicare" objectives in the N.H.S.; the extent to which the Service thus reflects the orientations of the providers as well as the consumers of medical services; the extent to which care was taken to give practitioners a strong voice in all the affairs of the Service; and the manner in which specific medical anxieties were disarmed. These anxieties included fear that clinical privacy and free choice might vanish,

that doctors might become mere salaried officials, that private practice might disappear, and that doctors would be assigned to practices without any genuine element of choice on their part.

It is difficult to avoid the impression that the very cooperativeness of the doctors in the process of medical reform made the N.H.S. more of a doctors' (less of a patients' or bureaucrats' or politicians') service than would otherwise have been the case. The Service was substantially constructed to achieve agreed positive ends rather than to allay sweeping and ill-defined anxieties. This undoubtedly helped to create an effective, now widely supported (though far from perfect) public medical scheme.

COST OF THE N.H.S.

(Continued from page 24)

mains a personal service. It means, though, that the Health Service is particularly vulnerable to price and wage increases and these factors alone account for 80 per cent of the increase in hospital costs since 1949. The costing system has revealed great discrepancies in the average costs of hospitals of similar type and efforts are now being made to devise procedures for the investigation of such discrepancies. Unfortunately, there is as yet no means of assessing the quality of work done in the various hospitals; for this reason, realistic comparisons are vitiated.

The real obstacle, of course, to effective cost control is that the power to spend money is widely decentralised among the 40 thousand doctors who operate the Health Service. Every day, every time they see a patient, these doctors commit the state to expenditure on behalf of their patients. This is as it should be and gives practical expression to the principles inherent in the National Health Service and the way in which it is financed: that medically qualified people can make medical decisions about their patients unhindered by the knowledge that the patient may not be able to afford the treatment they recommend.

BRITISH DOCTOR

(Continued from page 31)

of hospital privileges for general practitioners increases the sense of dissatisfaction, as the would-be consultant realizes that the only way in which he can maintain a close relationship with hospital practice is for him to hope that he will eventually reach consultant status.

The many attempts by the British Medical Association to improve the general practitioner facilities in hospitals have so far been unavailing, partly because of the lack of construction of new hospitals. This may be remedied to some extent through the projected building program of the Ministry of Health.

The Medical Officers of Health were grossly underpaid for many years, both before and after the inception of the National Health Service. The present salary scale varies with the population of the area which the Medical Officer of Health serves, starting at £2,170 (\$6,076) with a population of 75,000 and reaching £4,055 (\$11,354) for areas of 600,000. Thus the public health physicians in Britain today are paid reasonably well when compared with their colleagues in general practice, particularly as they have no practice expenses to contend with.

CONCLUSION

In summary, then, the doctors of Britain have accepted the National Health Service as a *fait accompli*. The existing faults do not interfere with the provision of good medical care, although most physicians are constantly on the alert for any further encroachment upon medical practice by the government. There is, however, no question that the National Health Service has become firmly established. It remains to be seen how the British medical profession can improve the standard of curative and preventive medical care made possible by this controversial and adventurous experiment.

ADVANTAGES OF THE N.H.S.

(Continued from page 33)

carded and in its place the present arrangements were ultimately adopted. They have provided freedoms essential to efficient medical practice.

Any medical practitioner on the medical register may enter the Service and take patients on his list if he wishes; his entry cannot be refused, though his choice of area of practice may be limited. He is free to accept or refuse any patient who asks to come on his list, subject to a large over-all maximum. He is free to stay in the service as long as he wishes; there is no retiring age. He cannot be dismissed or removed, except by findings of a disciplinary tribunal, on which the profession is represented. Any complaints are heard by a committee consisting of equal numbers of doctors and laymen. A doctor has complete clinical freedom in the treatment of his patients. At the end of his period of service, he receives a pension calculated on his earnings in the service, which is available at or after 65 years of age.

SUMMARY

To summarize the advantages to the general practitioner, there is the security of a regular income paid monthly, the amount depending on the number of patients he has attracted. There is a pension on retirement. There is freedom from the uncertainty of fees in private practice, with the work of accountancy and the recovery of debts.

It may be fairly claimed that within the framework of the British National Health Service there has been developed a really good and complete service provided for the patient and given by the doctor. The government pays for and directs the service, yet the conditions laid down provide essential freedoms for patient and doctor. If, under these circumstances, less than good is found, it must result from some lowering of standards of behaviour by either the patient or the doctor.

BOOK REVIEWS

(Continued from page 49)

TILAK AND GOKHALE: REVOLUTION AND REFORM IN THE MAKING OF MODERN INDIA. By STANLEY A. WOLPERT. (Berkeley and Los Angeles: University of California Press, 1962. 370 pages, bibliography and index, \$7.50.)

Stanley A. Wolpert, Assistant Professor of History at the University of California at Los Angeles, has written a major work of biography and history on two of the precursors of the Indian nationalist movement. In the West, Gandhi and Nehru are the preeminent figures of modern India. Less known, but of considerable importance "in the labor of making modern India," were Bal Gangadhar Tilak and Gopal Krishna Gokhale. For the first time, we have a comparative analysis "of their lives and ideas." The result is a scholarly, exciting, authoritative portrait of the politics and intellectual movements of pre-Gandhian India.

Wolpert unfolds his narrative with skill and compelling interest. He notes that "the social and political philosophies of Tilak and Gokhale developed initially from their different responses to the spread of Western ideology over the sub-continent of India in the wake of the consolidation of British rule." Whereas "Gokhale was attracted by the humanitarianism and liberalism of progressive Western thought," Tilak was immersed in the Hindu heritage and soon "began to view British rule as a predatory foreign incubus rather than a blessing." Gokhale believed that his countrymen's great need was for education.

Tilak, on the other hand, was a revolutionary, obsessed with the immediate quest for political power. Both made lasting and profound contributions to those who carried on their struggle for a free India.

A.Z.R.

THE MONTH IN REVIEW

A CURRENT HISTORY Chronology covering the most important events of May, 1963, to provide a day-by-day summary of world affairs.

INTERNATIONAL

Disarmament

May 10—The U.S. Disarmament Agency reveals it has asked the Massachusetts Institute of Technology to undertake a \$65,000 study of Soviet interest in disarmament and arms control. A second study will review regional arms control and disarmament possibilities; a third study will deal with inspection techniques.

May 13—After receiving a note from Soviet Premier Nikita Khrushchev, the U.S. cancels plans for 3 low-power nuclear tests in Nevada. Contents of the note from Khrushchev are not revealed.

May 27—Connecticut's Senator Thomas J. Dodd and Minnesota's Senator Hubert Humphrey lead a group of 24 Senators who ask the U.S. to offer the U.S.S.R. a treaty banning all atmospheric and underwater nuclear tests, a so-called first step agreement to break the test-ban treaty deadlock.

May 29—U.S. Secretary of State Dean Rusk reveals that 12 days ago he suggested an end to atmospheric and underwater nuclear tests to the Soviet Ambassador in Washington, who expressed no interest.

British Prime Minister Harold Macmillan approves a letter he and President Kennedy are sending Russian Premier Nikita Khrushchev suggesting a way around the continuing deadlock on treaty inspection.

European Economic Community (Common Market)

May 22—The U.S. reaches agreement with the E.E.C. on a general plan for reduced tariffs and freer trade; the U.S. concedes

that high individual tariffs should be cut more than relatively low tariffs where there are significant disparities and a substantial amount of trade. Actual tariff reduction will begin in May, 1964.

May 27—The E.E.C. reveals a 5-point plan for unifying transport policies in the 6 Common Market nations; no plan is set up for the Rhine.

May 31—French Foreign Minister Maurice Couve de Murville vetoes a Common Market proposal to maintain permanent continuing close contacts with Britain's Brussels-based mission.

European Free Trade Association

May 10—The 7 E.F.T.A. nations agree to eliminate all tariffs on non-farm products by the close of 1966.

General Agreement on Tariffs and Trade (Gatt)

May 16—Hans Schaffner, Economic Minister of Switzerland, opens a conference of 50 Gatt member nations.

May 18—International agricultural agreements are supported in principle by the U.S., the Common Market countries and several major agricultural producing nations. No formula is discovered by the U.S. and the Common Market for reduction of tariffs on non-farm commodities.

North Atlantic Treaty Organization

May 22—The Ministerial Council of the North Atlantic Treaty Organization approves a ten-nation allied nuclear force.

Organization of African Unity

May 16—Foreign ministers of African states attending a conference on African unity at Addis Ababa close the meeting to non-African observers.

May 25—Thirty African states form a loose federation, an Organization of African Unity; their charter calls for cooperation in the fields of politics, economics, defense and education. A Commission on Mediation and Conciliation is established. Heads of member states are to meet annually.

Organization of American States

May 6—At an emergency meeting of the O.A.S. Council, the Organization of American States asks Haiti and Dominican Republic presidents to settle their dispute peacefully through the machinery of the inter-American system.

May 8—The O.A.S. sends a special mission back to Haiti to try to avert an open break between Haiti and the Dominican Republic. (See also *Haiti*.)

United Nations

May 6—Haiti asks the Security Council to meet to discuss the Dominican Republic's threat to invade Haiti. (See also *International*, *O.A.S.*, and *Haiti*.)

May 7—The Security Council approves Kuwait as the 111th member of the U.N.

May 13—It is reported at the U.N. that Bolivia, Cuba, Hungary, Paraguay and the U.A.R. have paid enough of their overdue assessments to assure the validity of their votes in the General Assembly.

May 14—The General Assembly unanimously elects Kuwait as its 111th member. The special session on financing peace-keeping operations refers the financial problem to the Administrative and Budgetary Committee.

May 21—U.N. officials agree that Haiti has lost her voting rights in the General Assembly because of unpaid assessments.

Vladimir Pavlovich Suslov of the U.S.S.R. succeeds the late Y. D. Kiselev as Under Secretary for Political and Security Council Affairs.

May 22—The U.S.S.R. notifies the U.N. it will not pay its share of any U.N. expenses "unlawfully voted" by the General Assembly.

ALGERIA

(See also *France*.)

May 4—Welcoming U.A.R. President Gamal Abdel Nasser to Algiers, Algerian Premier Ahmed Ben Bella praises the new union of Iraq, Syria and the U.A.R., and declares that Algeria may someday join the federation.

May 5—Foreign Minister Mohammed Khemisti dies; on April 11 he was shot by an Algerian.

May 18—Ben Bella arrives in the U.A.R. for a 4-day visit.

ARGENTINA

May 12—The 11 Cabinet members in the government of President José María Guido resign. The Cabinet break-up protests demands by Interior Minister General Enrique Rauch for authority to purge Peronists and followers of ex-President Arturo Frondizi.

March 13—In an army bulletin, Army Commander in Chief General Juan Carlos Onganía states that a newly elected constitutional government will take office by October 12, 1963. President Guido accepts Minister Rauch's resignation. General Osiris Villegas is named interior minister. Guido also accepts the resignations of War Secretary Lieutenant General Benjamin Rattenbach and Economics Minister Eustaquio Mendez Delfino.

May 17—A presidential decree is issued forbidding the Union Popular (Peronist-front) party to nominate candidates for the presidency or the provincial governorships; the U.P.P. may seek only legislative posts in the July 7 national election.

BRAZIL

May 23—Finance Minister Francisco San Tiago Dantas receives a vote of confidence on his anti-inflation program at a Cabinet meeting.

BRITISH COMMONWEALTH

Australia

May 9—The U.S. and Australia sign an agreement permitting the U.S. to establish a major Navy communications center in Western Australia, with the U.S. gaining sole operational rights for at least 25 years.

Canada

May 3—At the conclusion of conferences with British Prime Minister Harold Macmillan, Prime Minister Lester B. Pearson declares that "in principle" Canada and Britain agree to President Kennedy's proposal for a 50 per cent across the board tariff reduction.

May 6—The Bank of Canada reveals a reduction in the bank rate from 4 per cent to 3.5 per cent.

May 11—Pearson confirms his intention to accept from the U.S. nuclear warheads for Bomarc-B missiles installed in Canada.

May 16—Canada's 26th Parliament opens. Pearson tells Parliament that it is vital to Canada's security to accept nuclear weapons from the U.S.

May 17—In Montreal, terrorists set off home-made dynamite bombs 6 times in residential mailboxes; the bombs are attributed to the Quebec Liberation Front, which would like to establish Quebec as an independent republic.

May 21—The House of Commons votes 124-113 to defeat a no confidence motion by those who oppose the Liberal government's nuclear policy.

Ceylon

May 1—Emergency rule in Ceylon ends after 743 days. The Tamil Federal party touched off the emergency on April 17, 1961, because of its disobedience campaign demanding a separate Tamil-speaking state. The ruling Freedom party now holds 73 seats in the Parliament and is faced with an Opposition of equal strength including the Tamil Federal party (15 seats), the United National party (29), Trotskyites (12), the Communists (4) and representatives of several smaller groups.

Great Britain

(See also *International, Disarmament*)

May 1—Winston Churchill reveals he will not run again for Parliament.

May 2—Minister of Defense Peter Thorneycroft meets Canadian Defense Secretary Paul Hellyer to discuss Canada's participation in an international nuclear force; Prime Minister Harold Macmillan confers with Canadian Prime Minister Lester B. Pearson. (See also *Canada*.)

May 7—Returns from municipal elections show Labor and Liberal party gains.

May 13—A 2-day conference of Commonwealth trade ministers opens in London.

The Government maintains a firm stand against the U.S. in a dispute over lower American air fares on North Atlantic routes. (See also *U.S., Government*.)

May 28—In a white paper, Parliament receives the Government's \$280 million housing program to clear the slums and eliminate shortages within a decade.

India

May 7—Prime Minister Jawaharlal Nehru tells Parliament that India will not negotiate with China unless the Chinese agree to the terms laid down by the Colombo conference.

May 8—It is reported from New Delhi that India has formally let the U.S. know she will accept mediation or good offices by a third party in the Kashmir dispute if Pakistan accedes to this.

May 15—Minister of Defense T. T. Krishnamachari arrives to talk to President Kennedy.

May 16—Indian-Pakistani discussions on Kashmir end in failure after 6 months.

May 21—The U.S. and India sign an agreement under which the U.S. will give India 4 loans totalling \$29 million to increase power and coal production.

In 2 of 3 by-elections, Nehru's Congress party is defeated.

May 22—Visiting Goa, Nehru promises that Goa will remain a "separate entity" as long as the Goans so desire.

May 27—China warns India that border "provocation" may lead to further fighting.

Malaya

(See *Indonesia*)

Nigeria

May 13—In England Chief Anthony Enahoro avoids deportation from England as his lawyers petition the Appeals Committee of the House of Lords for political asylum. Enahoro faces treason charges in Nigeria.

Pakistan

(See also *India*)

May 7—President Mohammad Ayub Khan leaves for a 4-day official visit to Nepal.

BRITISH EMPIRE

Bahama Islands

May 20—In London, a communiqué ending constitutional discussions promises internal self-government for the Bahamas possibly early in 1964.

Bermuda

May 16—In voting for a 26-seat House of Assembly, 11 Negro candidates are elected, the largest number of Negro members in the colony's history.

Kenya

May 27—Jomo Kenyatta's Kenya African National Union party wins in Kenya's national elections; he will become Prime Minister of Kenya.

May 28—Kenyatta is named first Prime Minister of Kenya.

May 29—Kenyatta's African National Union wins 64 of 112 elected seats in the House of Representatives; later returns are expected to give the party 77 seats. The party takes 19 Senate seats to give it effective control.

Swaziland

May 30—In a first step toward self-government, Swaziland receives a multiracial constitution from Britain, including a separate permanent electoral roll for the white

minority. The 24 elected members of the Legislative Council will include 8 members elected by the whites, 8 Swazis elected by traditional tribal methods, 8 members of any race elected by the national electoral roll.

BULGARIA

May 17—B.T.A. (official press agency) publishes a report to the Central Committee of the Communist party earlier this month. Party leader and Premier Todor Zhivkov announced, in the report, that "party, state and economic organs" have been reorganized to provide more centralization.

CAMBODIA

May 5—Communist Chinese Chief of State Liu Shao-chi signs a declaration of friendship with Prince Norodom Sihanouk.

CHINA, PEOPLE'S REPUBLIC OF (Communist)

May 2—Red Chinese seamen are rescued after their cargo freighter sank yesterday in the Yellow Sea. The Japanese Maritime Safety Agency officials doubt the crew's story that the ship was torpedoed.

May 16—Ending his visit to North Vietnam, Chief of State Liu Shao-chi praises ex-Soviet dictator Joseph Stalin. In a joint statement issued by Liu and President Ho Chi Minh of North Vietnam, the current Soviet regime is criticized by implication. (See also *U.S.S.R.*)

CONGO, REPUBLIC OF THE (Leopoldville)

May 1—It is reported that Premier Cyrille Adoula has asked Belgium for direct aid in retraining the Congolese army. Negotiations for retraining Congolese troops under U.N. supervision have broken down. Sources say that Adoula will also ask Israel, Canada, Italy and Norway to help directly in military retraining.

May 3—General Joseph D. Mobutu, army commander, stamps out a revolt by 3,000 policemen in Leopoldville.

May 8—Premier Cyrille Adoula ends a 4-day visit to Nigeria.

May 14—It is reported that the U.S. will give supplies and equipment to the Congo for retraining army troops.

May 19—U.N. troops take over Dilolo, on the Angolan border. It is reported that Katanganese gendarmes are gathering there.

May 22—Premier Adoula tells the U.N. that Nigerian police officers will help retrain the Congo army.

May 24—At the palace of ex-secessionist President Moise Tshombe of Katanga, U.N. and Congolese forces demand that he order his guards to yield their weapons and surrender. Tshombe refuses to surrender his personal guards, but gives up their weapons.

May 28—The Congolese Senate approves a bill to divide Katanga Province. It was approved by the House of Representatives last week. The new area will be known as Lualaba Province, will be composed of one-half the land and people of Katanga, and will have a large share of its rich mineral deposits.

CUBA

May 3—Cuban and Soviet officials meet in Moscow for economic talks. (See also *U.S.S.R.*)

May 20—Cuban exiles in Miami form the Cuban Committee of Liberation, dedicated to fight to restore Cuban independence.

DOMINICAN REPUBLIC

(See also *Haiti*.)

May 2—President Juan Bosch declares that he will ask all the American nations to cut off relations with Haiti.

May 4—The Dominican Republic threatens an invasion of Haiti unless safe conduct is granted to enemies of the Haitian government who have taken asylum in the Dominican Embassy in Haiti.

ECUADOR

(See *U.S. Foreign Policy*.)

FRANCE

May 1—The French News Agency announces that France will erect a nuclear test base in the Pacific Ocean at the Tahiti islands.

May 2—France and Algeria agree on revision of the 13-month old accords ending the Algerian war. The revisions provide for the removal of French troops in Algeria by the end of 1964 instead of July 1, 1965, and for the compensation of Europeans whose property has been nationalized.

May 18—France and Monaco sign an agreement ending their tax war.

May 22—France and Guinea sign an agreement for technical aid and cultural relations.

GERMANY, DEMOCRATIC REPUBLIC OF (East)

May 6—A.D.N. (official press agency) reports that U.S. Captain Alfred Svenson has defected to East Germany, one day after another U.S. soldier, Sergeant Benjamin Cain, defected.

GERMANY, FEDERAL REPUBLIC OF (West)

May 16—The West German Chamber of Deputies approves the Franco-German Treaty of Reconciliation.

May 17—Foreign Minister Gerhard Schroeder tells the British Ambassador to Bonn that West Germany will demand British adherence to the Nato embargo on steel pipe exports to the U.S.S.R. It is reported that a British company may be ready to sell pipe to Moscow.

May 27—Ex-Defense Minister of West Germany Franz Josef Strauss arrives in Israel for a 10-day visit. (See also *Israel*.)

May 31—The Bundesrat (upper house) approves the Franco-German treaty of reconciliation. This completes ratification.

HAITI

(See also *Int'l, O.A.S. and Dominican Republic*.)

May 1—It is reported that political foes of President Francois Duvalier have been massacred.

May 2—The U.S. issues a warning urging Americans to avoid travel to Haiti because of the tense situation there. The U.S. also protests the harassment of U.S. personnel

by the Haitian government. An O.A.S. commission, investigating the Dominican-Haitian conflict, departs. The conflict concerns the violation of diplomatic immunity following last month's surrounding of the Dominican Embassy in Port-au-Prince by armed soldiers. The Dominican Republic charges that safe-conduct exits have been refused to 22 foes of Duvalier, who have taken refuge in the Dominican embassy. Haiti has agreed to release 15 of the 22, but charges that the remaining 7 are responsible for plotting against Duvalier's life.

May 4—It is reported that a U.S. Navy task force with Marines abroad has been ordered to waters 30 miles off Port-au-Prince.

May 12—Louis Dejoie and Daniel Fignole, 2 exiled Haitian leaders, announce that they have formed a government in exile.

May 15—President Duvalier's constitutional right to office ends. His legal term expires today.

May 17—The U.S. suspends diplomatic ties with Haiti; the U.S. Ambassador and his delegation will remain in Haiti.

May 21—Violence continues in Port-au-Prince following its outbreak last night by anti-Duvalier terrorists.

May 22—Duvalier addresses 50,000 Haitians and tells them that their future will be "difficult." The speech marks the peak of the ceremonies for Duvalier's second inauguration.

HUNGARY

May 7—An official of the Roman Catholic Church meets with Hungarian leaders. Sources declare that the meeting is to negotiate the release of Jozsef Cardinal Mindszenty.

May 18—The official Polish press agency reports that Hungarian Premier Janos Kadar and Polish Premier Wladyslaw Gomulka have met secretly in Poland the past 2 days.

INDONESIA

May 1—Indonesian sovereignty over West Irian (Netherlands New Guinea) becomes effective. West Irian has been under U.N. authority since October 1, 1962.

May 18—The 623-man Congress unanimously names Sukarno president for life. Congress members were appointed by Sukarno.

May 31—President Sukarno meets in Tokyo with Malayan Prime Minister Prince Abdul Rahman to discuss the projected union of Malaysia. (See also *U.S. Foreign Policy*.)

IRAQ

(See also *U.A.R.*)

May 10—It is reported that the Iraqi government has ordered the arrests of pro-Nasserites in Baghdad and Mosul. It is also reported that the Baath party (ruling party in Iraq) has voiced its support for Syrian Baathists in their fight with Nasserites.

May 11—Sources disclose that the Iraqi government and Kurdish rebels have begun negotiations on the Kurdish demand for autonomy.

The Iraqi Cabinet resigns. Premier Ahmed Hassan el-Bakr will form a new government, presumably more in favor of Arab unity under President Nasser of the U.A.R.

May 13—It is announced that Baathists hold the key jobs in the new Iraqi government.

May 25—The Iraqi Revolutionary Council announces that it has discovered and stopped a conspiracy to overthrow the government. The plot was organized by pro-Nasser supporters.

May 29—It is reported that last night Iraqi Deputy Premier Ali Saleh el-Saadi declared the Baath party is more important than Arab unity.

ISRAEL

May 21—Schneor Zalman Shazar is elected third president of Israel by the Knesset over Peretz Bernstein. Shazar succeeds Itzhak Ben-Zvi.

May 25—Small demonstrations in Tel Aviv and Jerusalem protest the coming visit of ex-Defense Minister of West Germany Franz Josef Strauss.

May 28—Strauss and Ben-Gurion meet for 2 hours.

ITALY

May 16—Premier Amintore Fanfani and his

Cabinet resign after the Italian parliament convenes.

May 25—President Antonio Segni asks Aldo Moro, political secretary of the Christian Democratic party, to form a new government.

JAPAN

May 14—Japan and France sign a new trade agreement under which France will free or liberalize import quotas on over 60 Japanese products. The treaty renounces article 35 of GATT, which permits members to discriminate against Japanese goods.

KOREA, SOUTH

May 4—The Cabinet “recommends” unanimously that General Chung Hee Park run for the presidency later this year. Park is head of the ruling military junta.
May 11—General Park declares that general elections will be held this fall.

LAOS

May 2—Premier Souvanna Phouma confers with pro-Communist leaders.
May 3—Two helicopters belonging to the International Control Commission for Laos are shelled and burned in the Plaine des Jarres.
May 10—British Foreign Secretary Lord Home charges that the pro-Communists are frustrating the Geneva agreement on Laos. Lord Home rejects a Soviet suggestion that Vientiane be neutralized and that a police force representing the 3 warring factions in Laos be created in Vientiane.
May 17—U.S. officials report that the U.S. has told Poland that unless she cooperates with the International Control Commission on Laos, the U.S. will not attempt to restore most favored nation status to Polish imports. The Polish member of the I.C.C. has obstructed the group’s work.
May 21—It is announced that heavy fighting has taken place on the Plaine des Jarres for the last 2 days between Pathet Lao forces and neutralist troops.
May 22—It is reported that the Polish rep-

resentative to the I.C.C. has been called back to Warsaw for talks.

May 29—Britain and the Soviet Union send a message to Premier Phouma appealing for talks between the 3 warring factions. The message also urges restoration of “peace, concord and strict neutrality” in Laos.

May 31—*Tass* (Soviet press agency) publishes a draft of a Soviet message to the I.C.C. on Laos demanding that all I.C.C. decisions be unanimous. The Polish member has charged that actions have been taken by the other 2 members without his consent. The Soviet draft was presented to Britain earlier this week with the proposal that it be endorsed by the co-chairmen.

LIBERIA

May 7—Elections to the presidency are held. President William Tubman runs unopposed.

MOROCCO

May 19—Unofficial complete returns indicate that the royalist Front for the Defense of Constitutional Institutions won 69 seats in the House of Representatives; the Istiqlal party, 41 seats; the National Union of Popular Forces, 28; and independents, 6.

NETHERLANDS, THE

May 16—Premier Jan de Quay’s Catholic People’s party wins yesterday’s general elections to Parliament with a total of 50 seats in the 150-member lower house. The Labor party wins 43 seats, the Protestants 26, and the Liberals 11. The remainder went to smaller parties.

The 11 provincial councils vote for the upper house composed of 50 seats.

May 20—Queen Juliana asks Roman Catholic party member Carl P. M. Romme to form a coalition government.

SENEGAL

May 11—Ex-Premier Mamadou Dia is sentenced to life detention for treason.

SOUTH AFRICA

May 17—The South African parliament approves partial self-government for the

Transkei territory (an all-African area or bantustan) with an African parliament, separate flag, national anthem and language.

SYRIA

- May 3—It is reported that last night 5 Syrian Cabinet ministers, supporters of President Nasser, resigned. The Defense Minister and a ranking army officer also resign in support of the 5. The resignations end the coalition between the Baathists and 3 Nasserite groups. The crisis began earlier this week when 47 Nasserite officers were ousted.
- May 4—The U.A.R. announces that talks among the U.A.R., Syria and Iraq on military unity have been postponed.
- May 8—Pro-Nasser riots are staged in Damascus and in north Syria. (See also U.A.R.)

A Syrian delegation led by General Louai el-Attassi departs after conferring in Cairo with U.A.R. officials.

- May 11—Premier Salah el-Bitar (Baathist) resigns. Sami el-Jundi (a pro-Nasser supporter) is named to form a new government.
- May 13—Following el-Jundi's failure, Premier el-Bitar returns to office at the head of a Cabinet that is led by the Baath Socialist party.
- May 26—It is reported that on May 22 a pro-Nasser plot against the government was extinguished. Some 40 officers and non-commissioned officers are discharged and their two leaders are arrested.

TOGO

- May 5—Elections to parliament are held. There is a single list of candidates, representing all the political parties. Victory is assured for the provisional government of President Nicholas Grunitzky.

TURKEY

- May 21—Rebels led by an ex-colonel attempt to overthrow the government. They are defeated by government forces.
- The Supreme Security Council orders martial law in Istanbul, Izmir and Ankara after a war college cadet revolt.

U.S.S.R.

- May 1—In a May Day celebration, some 250,000 marchers in Red Square parade before Soviet Premier Nikita Khrushchev and Cuban Premier Fidel Castro.
- May 3—Second Secretary of the Central Committee of the Communist Party Frol R. Kozlov is reportedly ill. Kozlov has been regarded as Khrushchev's successor.
- May 4—The Central Committee announces that Kozlov was not able to attend May Day ceremonies because of illness.
- May 7—Greville M. Wynne, British businessman, and Oleg V. Penkovsky, deputy head of the foreign department of the State Committee for the Coordination of Scientific Research, go on trial. They plead guilty to charges of espionage for the U.S. and Britain.
- May 10—Communist China tells the U.S.S.R. that it has appointed a delegation of leading Chinese Communists to attend an ideological conference in Moscow.
- May 11—The Military Collegium of the Soviet Supreme Court sentences Penkovsky to death. Wynne is sentenced to 3 years in prison and 5 years in "labor colonies."
- May 13—*Tass* (official press agency) reports that a meeting of the Central Committee of the C.P.S.U. has been postponed from May 28 to June 18.
- May 15—The Central Committee announces that Mikhail A. Suslov, member of the Presidium, will head the delegation to meet with the Chinese Communists on settling ideological differences.
- May 16—A reorganization of the Academy of Sciences to centralize research in the social and physical sciences is announced by *Pravda* (Communist party paper). The reorganization, ordered by the Central Committee and the government, places 14 local academies in the republics under the authority of the Academy of Sciences.
- Tass* reports that contact with the Mars I space vehicle launched in November, 1962, has been lost since March 21.
- Tass* announces that Penkovsky has been executed.

May 23—Khrushchev tells a "friendship meeting" in honor of Cuban Premier Castro that the U.S.S.R. will defend Cuba against an attack or blockade by the U.S.

May 24—A joint statement by Khrushchev and Castro is made public; Khrushchev accepts an invitation to visit Cuba.

May 28—*Tass* announces that 2 Soviet rockets have been fired 7,500 miles into the Pacific target area.

UNITED ARAB REPUBLIC

May 8—U.A.R. President Gamal Abdel Nasser leaves Algeria after a 5-day visit. (See also *Algeria*.)

May 16—Nasser ends a 5-day visit to Yugoslavia.

May 26—Sources report that the projected Arab Federation of Syria, Iraq and the U.A.R. may not materialize. (See also *Iraq* and *Syria*.)

UNITED STATES

Agriculture

May 21—The Administration's wheat-production control plan is rejected by wheat farmers; all mandatory production controls on wheat will be eliminated starting in 1964.

Foreign Policy

May 7—Dependents of U.S. government personnel in Haiti are ordered by the U.S. to leave Haiti; other U.S. citizens receive U.S. offers of aid to evacuate the island. (See also *Haiti*.)

May 21—President Kennedy reveals that Admiral George W. Anderson will be named Ambassador to Portugal; Anderson is the outgoing Chief of Naval Operations.

May 24—At an airline conference in Montreal, airlines compromise their dispute over New York-Paris round trip economy rates. The Civil Aeronautics Board refused (March 19) to permit 2 U.S. lines to raise round trip rates 5 per cent to conform to a unanimous vote of the International Air Transport Association. The higher rates will be in effect until July 15; then new, compromise rates will go into effect.

May 29—U.S. Secretary of State Dean Rusk

asks Ecuador to release two U.S. tuna fishing boats seized yesterday fishing some 13 miles off the Ecuadorean coast. Ecuador claims a 200-mile limit to her territorial waters; the U.S. recognizes only a 3-mile limit.

Indonesian President Sukarno confers on oil policies in Tokyo with U.S. officials.

May 30—The U.S. and Britain announce an agreement increasing 10 times the standby currency that can be exchanged by the two nations if either is threatened by speculation or if foreign currency is needed to support gold losses.

Government

May 1—Delaware becomes the 33d state to ratify the anti-poll tax amendment to the Constitution; this would become the 24th amendment.

Assistant Deputy Attorney General Joseph F. Dolan warns that a "states rights" amendment on reapportionment, approved by 12 states, may become a tool for disfranchising Negroes. Two other "states rights" amendments now being considered in state legislatures are criticized by Dolan.

May 14—Newton Minow resigns as chairman of the Federal Communications Commission; E. William Henry, a member of the commission, is named to replace him.

May 15—The President's Science Advisory Committee warns of the potential health hazards of indiscriminate use of chemical insecticides. Changes in legislation and administrative practices are demanded.

May 23—President Kennedy receives legisla-

tion from the Senate ending the government's policy of backing one and two dollar bills with silver. The Senate votes 68-10 to replace silver certificates with federal reserve notes backed with 25 per cent gold. The measure was asked by the Administration in 1961.

May 28—A bill requiring equal pay for women working in interstate commerce goes to the White House.

The Senate approves and sends to the President a two-step rise in the national debt limit to a record \$309 billion. The

Treasury reports that the debt will rise some \$200 million above the current limit on May 29.

Labor

May 14—A presidential emergency board makes public its recommendations for mediating the railroad works rules dispute.

May 25—President Kennedy names 12 members of a national labor-management panel to advise the director of the Federal Mediation and Conciliation Service in the area of strikes and threatened strikes. The President is acting under authority granted to him by the Taft-Hartley Act of 1947.

Military Policy

May 6—President Kennedy names Admiral David McDonald Chief of Naval Operations, replacing Admiral George W. Anderson.

May 7—A second Telstar satellite goes into elliptical orbit.

May 14—The Department of State reveals that Britain and the U.S. have agreed to build a \$95 million undersea weapons testing center in the Bahama region.

Authorization for more than \$15.3 billion in military purchases is passed in Congress and goes to the White House.

The 22-orbital flight of Major L. Gordon Cooper is postponed because of a radar breakdown in Bermuda.

May 15—Cooper begins a 22-orbit flight in the space capsule Faith 7.

May 16—Cooper lands safely 7,000 yards from the carrier U.S.S. Kearsage after an almost perfect 22-orbit flight; the astronaut uses manual controls for a landing when automatic controls fail. Cooper is in excellent health.

May 17—The National Aeronautics and Space Administration says that its recent secret launching of millions of copper "needles" into outer space is successful and will "create no significant interference with any other scientific activity."

May 23—It is reported from Portland, Oregon, that the City Council has voted to abandon its civil defense program as of July 1.

May 27—The Oregon state legislature rejects a budget appropriation to continue its civil defense program.

May 28—Hearings on federal civil defense open under the aegis of the House Armed Services subcommittee. Counsel for the subcommittee criticizes the administration's proposed shelter program as technically unsound.

Politics

May 2—Senate Republican Whip Thomas Kuchel of California charges that members of the John Birch Society and other right-wing "fright peddlers" are more harmful to the nation than the Communists.

May 4—New York Governor Nelson Rockefeller marries Mrs. Margaretta F. Murphy in a surprise ceremony; the Governor was divorced 14 months ago after 31 years of marriage; Mrs. Murphy divorced Dr. James Murphy in April.

Segregation

(See also *Supreme Court*.)

May 2—More than 400 young Negro demonstrators are arrested after street demonstrations for racial equality in Birmingham, Alabama.

May 3—Police dogs and fire hoses disperse Negro student rioters in Birmingham.

May 6—Some 1,000 Negroes are arrested in Birmingham as protest marches continue.

May 7—Some 2,500–3,000 demonstrate in the business section of Birmingham; rioters are driven back by police and firemen.

May 10—Birmingham's white business and civic leaders reach full agreement on limited desegregation as a biracial committee report ends the 5-week crisis. City and state officials do not participate in this agreement.

Malcolm X, eastern leader of the militant Negro group, the Black Muslims, criticizes Martin Luther King's tactics and the use of Negro children in the Birmingham demonstrations.

Twenty-eight Negro children continue to "sit in" at the almost all-white Cleveland School in Englewood, New Jersey, in a pro-

test against *de facto* school segregation.
 May 11—Birmingham's Public Safety Commissioner Eugene Connor declares that white citizens should boycott merchants who have agreed to end segregation in their stores.

May 12—President Kennedy sends federal troops to bases near Birmingham, after 2 Negro residences are bombed; 50 are injured in more than 3 hours of rioting.

May 14—34 Negroes are arrested in Raleigh, North Carolina, as they protest segregation in downtown eating places.

The New Rochelle, New York, Board of Education publishes a plan to correct racial imbalance, reorganizing the public schools and providing free bus service to all public and private students at a specified distance from their schools.

May 16—The New Jersey State Commissioner of Education orders Orange, New Jersey, to submit a plan to end *de facto* racial segregation in its Oakwood School before September.

May 18—A drive against segregation in northern schools is announced by the National Association for the Advancement of Colored People.

In a one-day Southern tour President Kennedy supports Negro demands for civil rights. He meets Alabama's Governor.

May 20—Some 1,100 Birmingham Negro students are suspended or expelled for anti-segregation activities.

In the sixth night of protest, some 80-100 Negro marchers are arrested in Greensboro, North Carolina.

May 21—Federal District Judge H. H. Grooms orders the University of Alabama to admit 2 Negroes June 10.

When the mayor reveals that 7 drive-in restaurants have agreed to desegregate, mass demonstrations are suspended in Durham, North Carolina.

May 22—Chief Judge Elbert Tuttle of the Fifth Circuit Court of Appeals ordered 1,100 Birmingham Negro students reinstated after their suspension for demonstrations.

May 23—The Alabama State Supreme Court

rules that moderate Mayor Albert Boutwell and a new city government are entitled to office in Birmingham. When the Board of Education yields to court order, 1,100 Negro pupils return to their classrooms.

May 24—Attorney General Robert Kennedy meets privately with some prominent Negroes to learn their views on Northern discrimination against Negroes. Leaders of civil rights organizations are not present. No agreement is reached.

May 28—Two Negroes and a white college professor are beaten and kicked as they sit-in to protest segregated lunch counter facilities in Jackson, Mississippi.

A federal judge refuses to order total desegregation for Birmingham's public schools because the school board's "good faith" in desegregation has not yet been tested.

A federal judge orders the University of Mississippi to admit a Negro student to its law school for the summer term.

The National Association for the Advancement of Colored People files a suit in a Washington, D.C., federal district court asking reduced representation in Congress for states which deny Negroes the vote. Section 2 of the 14th amendment calls for such reduction of House seats if states deny or abridge citizens' voting rights.

May 29—President Kennedy asks 9 Democratic governors (including one Southerner) to take a firm stand on civil rights.

In Jackson, Mississippi, 19 demonstrators are arrested.

A federal district court judge rules that the Department of Justice cannot bring suit in Huntsville and Madison County, Alabama, for a school system desegregation.

May 30—Memphis complies with the Supreme Court's desegregation order for recreational facilities but closes swimming and wading pools.

Vice-President Lyndon Johnson tells a Gettysburg, Pa., audience that white and Negro Americans must work together within the law for Negroes' civil rights.

In Tallahassee, Florida, police disperse 150 Negro demonstrators with tear gas.

May 31—In Jackson, Mississippi, some 600 marching Negro children are jailed.

Supreme Court

(See also *Segregation*.)

May 20—Ruling in a series of sit-in cases, the Court holds that if a city ordinance or official statement make segregation an official policy Negroes cannot be prosecuted for asking for service in privately owned stores, because this type of public policy is unconstitutional. Convictions of 31 sit-in demonstrators are set aside.

The Court rules 7 to 2 that the New York Stock Exchange is subject to anti-trust regulation.

May 22—Chief Justice Earl Warren asks for a "great national debate" on the three "states' rights" amendments to the Constitution. (See also *Government*.)

A 4-4 decision of the Court in effect upholds a District Court decision allowing the state of New York to end railroad rate differentials that favor Southern coastal ports. Differential rates were set in 1877 and have been protested for 85 years.

May 27—The Court rules unanimously that segregation in parks and playgrounds in Memphis, Tennessee, must end at once; the Court warns also that segregation in public schools will not be permitted indefinitely.

VATICAN, THE

May 11—Pope John XXIII pays a call on Italian President Antonio Segni, the first Pope to call on a president of the Italian Republic.

May 29—Pope John XXIII's condition improves. Yesterday an official statement described his illness as heteroplasia (meaning tumor).

May 31—Pope John receives the sacrament of extreme unction; he is near death.

VIETNAM, SOUTH

May 6—It is reported that Viet Cong guerrillas attacked and killed a U.S. army lieutenant and 2 South Vietnamese.

May 9—It is reported that South Vietnam has

agreed to pay for all the costs (\$17 million) of the "strategic-hamlet program," essential to its fight against the Viet Cong rebels. The agreement was made with the U.S.

May 18—It is reported that in the Plain of Reeds, South Vietnamese troops killed at least 40 Viet Cong guerrillas and captured some 12.

May 22—U.S. President Kennedy, at his news conference, declares that the U.S. will remove its troops from South Vietnam if requested. There are some 12,000 U.S. soldiers currently based there.

YEMEN

May 23—The text of a speech by U.A.R. President Nasser (delivered 2 days ago) is received in Washington; Nasser declares U.A.R. troops will remain in Yemen until the royalists have been put down. Nasser is violating a "disengagement" agreement reached last month, which provided that Saudi Arabian aid to Yemeni royalists would cease and U.A.R. troops supporting the rebels would be withdrawn.

May 28—It is reported that beginning some 2 weeks ago, royalists under Imam Mohammed al-Badr stepped up attacks against the rebel government.

May 29—U.S. Secretary of State Rusk declares that Egyptian troop withdrawal from Yemen will begin very shortly; it depends on U.N. observers being present in Yemen soon.

YUGOSLAVIA

May 4—In Belgrade, U.S. Secretary of State Dean Rusk meets with President Tito.

May 12—U.A.R. President Nasser arrives for a visit with Tito.

May 18—Speaking before the Central Committee of the Yugoslav League of Communists, Tito declares that "favorable conditions" exist for an improvement in relations with the Communist bloc countries. He condemns the Chinese Communists, and praises the Soviet leadership. He also speaks of improving relations with the nations of the West.

May 25—Tito celebrates his 71st birthday.

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